DEATH AND DYING

(Ministering to the dying, their family and friends)

by

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Dean

There is a time to be born and a time to die . . .

A time to weep and a time to laugh;

A time to mourn and a time to dance . . .

A time to rend and a time to sew up the rent;

A time to be silent and a time to speak . . .

Ecclesiastes 3

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ABSTRACT

Our contemporary society addresses the subject of death with an attitude of denial. Within this framework, the institutions, programs and personnel who are involved with the dying are cautiously directed by Western Cultural traditions. The results of these attitudes effect the process of preparation for both the dying and the others who are effected, namely, family and friends.

Critical of the traditional approaches to the treatment of the dying, this project procedes with a variety of options from the respective readings, experiences, and studies in this important area. It provides an overview of the aspects of death and dying, including concern with the patient, family and friends. The project attempts to deal with the key word, namely separation.

The works of Dr. Elisabeth Kübler-Ross, Dr. Edwin Shneidmen, and Dr. Ciciley Saunders are all significant in the modern treatment of this all important subject. Not only how the person is treated but, more important, how the person should be treated becomes the purpose of this project.

A major consideration which need be dealt with, is that of "need." How we address ourselves to the needs of those who are involved in this total experience, are extremely significant and can be meaningfully dealt with.

I am of the belief that one of the most significant persons dealing with death and dying, is the clergyperson. How the clergyperson approaches the subject is extremely significant.

"The rights of passage," are significant in that they become instruments of learning from which each of us can draw, and it is, therefore, significant that we view this material from the point of view of the enrichment of the total person. We view the problems of preparation for death and dying, thereby placing death in a most meaningful relationship to life.

Clearly, the array of solutions with which we are confronted in our society have a historic tradition which is religiously oriented. With this in mind, an appendix of Jewish customs and traditions, founded on Jewish law, can be of help to a person who is interested in having the rituals and ceremonies to assist him at this significant time in his life.

There is no purpose in creating a sugar coating to a concern which is filled with anxieties and perplexities. The purpose of this project is to present, in light of historic attitudes, alternatives to deal with the helplessness which is the by-product of the older approaches.

If indeed, the problem of meeting the emotional and physical needs of the dying person, relatives and friends has been treated properly by the entire health team, then death and dying is viewed as one additional

phase of life.

If birth is a beginning, and death a destination then life need be a growing from stage to stage. These stages bring us from birth to death. This project is directed to make death and its stages part of a meaningful life.

CHAPTER I

INTRODUCTION

Life is surrounded by a variety of different mysteries, and certainly the mystery of death is a major one which man has attempted to deal with. The understanding that we search for is an attempt to make our earthly journey more meaningful. Our purpose is to develop our ability to understand our role in helping ourselves and others when we approach the reality of death.

Time and Purpose

King Solomon, in his wisdom identified that for everything there is a purpose and to every experience in life a definable time schedule, from birth to death. Clearly, within the framework of our society, we have dealt with those aspects of experience which deal with "life." But we have not addressed ourselves to the general area called "death and dying."

Shifting Focus

In our effort to find some form of expression, some normalcy in dealing with the problems of death and dying, the pendulum has swung from one extreme to the other. In

recent years there has been a re-awakening of concern in this area, and efforts have been made to establish a sort of normalcy which will address itself in a very real way to how one acts and reacts at the time of anticipated death or how one reacts and responds to the pain and loss at the approach of death.

Concept and Interpretation of the Concept

In an article[1] Joan Kron, made the point that we need a therapeutic environment from the patient's point of view, which includes an at-home feeling. This particular observation presents its own problems, namely, what is the patient's point of view? How does one create or recreate a caring environment, a "home" feeling? This is the crux of the problem and translating the patients needs and desires to reality becomes the goal we must strive to attain.

Concept in Action

Elisabeth Kübler-Ross,[2] indicates that the need for family and the home setting is essential for a meaningful

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[1] Joan Kron, "Designing a Better Place to Die," New York Magazine (March 1, 1976).

[2] Elisabeth Kübler-Ross, On Death and Dying (New York: Macmillan, 1970).

environment for the dying patient. Cicely Saunders the eminent founder of St. Christopher's Hospice, has designed such an institution which establishes the home feeling designated to meet the emotional needs of the patient. In various communities throughout our country, as New Haven, Connecticut and Santa Barbara, California, similar buildings and programs are being established. All of these programs direct themselves to wards establishing a therapeutic environment and the home feeling considered essential, and most significant, considering the patients point of view.

Philosophical Points of Origin

I wish to explore some aspects of the question of "a family community -- a caring place." This atmosphere establishes a setting in which one can, in a sophisticated way, truly deal with the inevitable needs of a dying patient. Cicely Saunders called my attention to the philosophical points of origin of treating the dying person, namely, non-addictive medicine in anticipation of pain, which deals with the patient's greatest concern. Secondly, the establishment of a program showing human care with the concept of dignity. The hospice is intended to provide this type of "environment." If being human means caring, and if dying is part of being human, then, indeed, there is an obvious interrelationship between these areas of expression. We all enter the arena of our concerns with certain pre-conceived ideas, some of which are correctly or incorrectly founded. The purpose of

a hospice is to attempt, in a most correct way, to address itself to a program and atmosphere considered most natural to address itself to the needs of the patient. This program and environment must take into consideration an endless list of needs, from the physical housing of the patient to that aspect of privacy which preserve the rights of the individual, even in those last moments of their life.

A Better Place to Live

If, indeed, "this designing a better place to die" is to have meaning, it must direct its attention to a system of designing a better place to live. The latter has been one end of the pendulum which our society addresses itself to in this world of efficiencies and technology. This must, similarly, be applied to the other end of the pendulum as it relates itself to death. An adjustment in both of these areas brings us somewhere to the center of the question where we must deal with both aspects at the same time while emphasizing a system of worth for the individual at all times.

Method of This Project

The methods employed in this project are to bring together readings, experiences and studies from different sources that will attempt to bring some clarity and understanding to the entire subject of death and dying.

Purpose of the Project

The ultimate purpose of the project is to assist members of the clergy who are called on to counsel and to respond to the needs of those who are in the valley of decision making. These decisions deal with such matters as, what one does when a person is so terminally ill that he needs to be sent to an institution for care.[3] A major problem arises from societal attitudes towards the dying person and his needs; as well towards family and friends of the dying. These attitudes in turn have an affect the type of program offered to the terminally ill, their family and their friends. The further purpose of this project is to attempt to remove the idea, through understanding the materials available, that death is a taboo area. It is also vital that we recognize and acknowledge that our own fears and misconceptions are the dramatic roots that cause us to transfer rejection of death to the institution's which care for health, the hospital and the convalescent home. The most modern system of dealing with an environment of good health care can be supported when we establish a meaninful understanding of an environment of dying. At this point this project proposes to turn its attention to the "Hospice movement."[4]

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[3]Margaretta K. Bowers, Counseling the Dying (New York: Aronson, 1975), pp. 5-7

[4]Milton D. Heifetz, The Right to Die (New York: Putnam, 1975), pp. 153-66.

Exploring the Options

It is my intent to compare the programs and institutions to which we can turn. Above all, I am most interested in sharing materials that will broaden the base of understanding in dealing with the dying person. Clearly, the work of the pioneers in this field of thanatology is most significant. What are the options in terms of the modern treatment of the dying person? This project will give special consideration to the studies of Elisabeth Kübler Ross,[5] Edwin Shneidman,[6] and Cicely Saunders.[7]

Western Attitudes

In this, the introduction to the project, I wish to state that our concern will focus on attitudes of Western culture, and most specifically to the American attitude of denial of death. Our very language in dealing with this subject, substantiates this thesis. The terminology regarding the dying person, the care, the death and necessary funeral arrangement is contradictory. This then translates itself to the treatment of the dying person, denying them

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[5]Kübler-Ross, pp. 1-10.

[6]Edwin S. Shneidman, Deaths of Man, (New York: Quadrangle-New York Times, 1969), pp. 25-33

[7]Cicely Saunders "The Management of Patients in the Terminal Stage," in Ronald W. Raven (ed.) Cancer (London Butterworth, 1959), VI, 403-417.

a "rite of passage."[8] If nothing else, the options that rightfully belong to the terminally ill, the family and friends, are often not made available to them because of our American cultural attitude of dealing with death. Death touches the ebb and flow of the deepest feelings and relationships. In our western culture we have found refuge in euphamistic language. The truth is that death is not an illusion. The needs are clear, and we must attempt to identify them and deal with them.

Fear of Death as a Factor for the Clergy

The fear of death is not only a cultural phenomenon, but a fact of being human. The knowledge of life is far clearer than the unknowingness of death. The termination of relationships, as well as the natural joys of living, can well serve as a meaningful platform wherein the effective clergyperson attempts to minister to these issues while ministering to the needs of the dying, the family and friends. I therefore am appendixing to this project a section dealing with Jewish rituals and ceremonies that help to support the findings of Kübler-Ross, Shneidman and Saunders.

Changing Attitudes

Significant changes have taken place in recent years

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[8] Heibetz, pp. 4-9

regarding the contemporary attitude towards death and dying. Indeed, death is a profound event not only for the individual, but also for the society. The way we respond speaks to our ideas, beliefs, values and practices. The problems associated with death are polarized at two different points within our social structure. The first separates the aged from our society the second the terminally ill and we become less interested in them as individuals within our social system. These results constitute an important part of our problems of death, grief, and bereavement. Above all, it affects how we deal with the process of death.[9]

An additional aim then of this project is to deal in a humanistic way with one aspect of life and how it effects our behavior pattern in all aspects of life.

Additional Perspective

In a very real way, the questions which concern euthanasia and the right to the decision to terminate one's own life, whatever from this takes, becomes a very integral part of the overview regarding this project.[10] That I cannot deal with this important aspect of the subject in this project does not diminish its importance.

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[9]Elisabeth Kübler-Ross, Questions and Answers on Death and Dying (New York: Macmillan, 1974), pp. 88-93.

[10]Heifetz, pp. 99-117

The Historical Tradition of Clergy/Populace Relationship

The guideposts of behavior, established since the earliest of days, have focused on the unique intimacy between the clergy and the populace as well as the unique responsibility between the clergy, the dying person, the relatives and friends. In spite of the changes in society, the basic principles have not varied. The scope of this project is to deal with those areas that can effect a more responsible relationship to the aforementioned historical tradition. The concerns are to find better systems of bridge building for the dying and the relatives and friends. The limitations of this project are best seen through what it does not attempt to do. Firstly, the project does not present a full scale theological treatment of Death and Dying, though I would call to your attention the appendix which speaks to the Jewish rituals and ceremonies. Secondly, the project limits itself to three major writers in the field of Death and Dying, namely Kübler-Ross, Shneidman, and Saunders.

None of the aforementioned in any way diminishes from the obvious importance of care which needs to be tended to the dying. If, in some real way, I have addressed myself correctly to this entire subject, then our effectiveness in dealing with the questions of life and death draws together those aspects and philosophies of our earthly pilgrimage which give essential meaning to the totality, the complete overview of life.

Judeo-Christian Tradition

All of these observations do not, in any way, deny death. But, in a very real way, they address themselves to life and the rites of passage which are part of life, in which death is a category. Recently, a variety of well-respected persons from the field of science, released statements of individuals who testified that they had returned from death to life and that there is life after death. These reports put the subject of death into the theological concept of "life to life." This observation relates itself to a theological principle which is clearly part of the Judeo-Christian tradition. With this statement the theological and functional need integrate and the appendix of this project provides for the Jew a compatible and supportative system.

Understanding the Basic Concepts

In the research that I have done to try for a better understanding of death and dying as well as the teachings in this area, I returned to the most ancient of traditions which underscores sensitivity for the dying person and the circle of family and friends who are part of the event. None of this is intended to demean, but rather, to emphasize the importance of proper care for all of these persons who are kept contractually, as they were previously, in a relationship to each other.

A Merging and Emerging

We might choose to speak singularly about pain, decision making, acceptance, anger, guilt, or all of these, yet avoid the most essential question, namely, a fellowship which merges together the totality of experience.

It is my hope that the information and research contained within will help the clergy in dealing with these issues, and will aid the terminally ill and those involved with him in utilizing the experience so that death may be approached as another aspect of life.

CHAPTER II

STATEMENT OF PROBLEM

Tolstoy expressed our problem at its source, in the most powerful terms, when he wrote in his novel in 1886:

> What tormented Ivan Ilyitch most was the deception, the lie, which for some reason they all accepted, that he was not dying but was simply ill, and that he only need keep quiet and undergo treatment and then something very good would result. He however, knew that do what they would nothing would come of it, only still more agonizing suffering and death. This deception tortured him--their not wishing to admit what they all knew and what he knew, but wanting to lie to him concerning his terrible condition and wishing and forcing him to participate in that lie.[1]

The major complication in dealing with death is that we have not raised a generation of adults who can deal with death in a straightforward manner. Rather we have developed a sugar coated, diversionary, escapist system of covering up facts. The creation of anxieties and perplexities have caused a complicated, confused lack of understanding. Now, as this generation seeks understanding, we must be willing to realistically go into an indepth, corrective program to deal with the institutions and concepts as previously misrepresented by the traditions of society.

One of the key terms that we are confronted with, in

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[1]Leo N. Tolstoi, The Death of Ivan Ilyitch (New York: Charles Scribner's Sons, 1904).

terms of basics, is "Separation." It seems that we all have learned to be able to say, "I will die." The concept which grows out of this is:

1) I am an individual with a life of my own, a personal existence.
2) I belong to a class of beings one of whose attributes is mortality.
3) Using the intellectual process of logical deduction, I must arrive at the conclusion that my personal death is a certainty.
4) There are many possible causes of my death, and these causes might operate in many different combinations; although I might evade or escape one particular cause, I cannot evade all causes.
5) My death will occur in the future. By future, I mean a time-to-live that has not yet elapsed.
6) But I do not know when in the future my death will occur. The event is certain; the timing is uncertain.
7) Death is a final event. My life ceases. This means that I will never again experience, think or act, at least as a human being on this earth.
8) Accordingly, death is the ultimate separation of myself from the world.[2]

The institutions that are basic to our problem, are those placed in the difficult position of dealing with the "separation." An example of the type of separation we are exposed to, are the rules of institutions that children of certain ages are restricted from visiting. The element of unworthiness, and the mystery which separates, cause fear and conflict in the mind of the growing child. Then, as an adult, his discomfort is well anchored in early beginnings of doubt.

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[2]John Hinton, Dying (Harmondsworth, England: Penguin, 1967), pp. 149-151.

A. OUR SOCIETY AND THE DYING PERSON

Out of an interpretation of needs, our society has developed a series of strange misrepresentations regarding death. From this beginning, the pile of difficulties keeps amassing. We have now arrived at a time when our society has paused, hopefully, with an honest appraisal of the problem, and a series of meaningful questions to attempt to adjust and correct the situation.

What is the problem? Historically, the attitudes that were created were amassed bit by bit. We are taught, from the moment of birth that every living organism faces the inevitable end, death. How we live in most instances involves decisions we make ourselves. How we die is often colored by decisions that others make for us, particularly if a chronic illness precedes death by some length of time.

In the past, death most often occurred at home, but modern technology has lessened the importance of home as a place to die and has substituted the convalescent home as the prime sight of death. This change in locale has not evolved suddenly, but has taken place slowly over the past several decades, and probably results from the belief that modern medical miracles can offer life. We face the reality that medical science today, truly a miracle science when contrasted to practice of even 100 years ago, cannot prolong life indefinitely, and we adjust our thinking to utilize our resources efficiently, not rationally. The dying person has

unique needs, not really different from the gamut of emotions of his life, but more acute in their demand for fulfillment in that special setting of impending death. Time is indeed of the essence and a cavuum of rejection by family, acquaintances and even health professionals becomes evident as life ebbs.[3]

B. INSTITUTIONAL DEATH

Our society and the dying person are the results of cultural forces that were unplanned, and social accidents that came with specialization. Within this sociological system of change was death. Where death used to be a part of homelife and could be met openly and honestly, now due to different modes of living, it comes in the hospital, the convalescent home, the highway, and the battlefield. The Specialists who participate in death are skilled technically, but largely uninvolved emotionally. And the emotionally involved are remote from the events, and so are not able to cope with them realistically.

Growing up in the typical family of today we are subject to a type of circumstantial anxiety that did not exist so markedly in the past. Until quite recently the family tended to be multigenerational, with parents, children, grandparents, and other assorted relatives nearby. When death occurred in that setting it was possible for the

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[3]Ibid., p. 81.

emotions to be diffused with a variety of people to talk with. While the experience of death might not have been pleasant, it was not remote, and could be dealt with realistically, in both the event and the feelings that went with it. The things feared were met directly and openly. There was little pretense or illusion about the major events of life.

1. How it Affects the Dying Person

Now that kind of pattern of family living is largely outmoded.[4] The old folk take their social security and move to a retirement village, or a part of the country populated largely by those in the 65-and over age group. The basic family unit tends to be a father, a mother, and two or three children. The family, as such, begins with marriage and ends with or is broken by the death of one of the parents. This threat hangs so heavily over all the members of the small family unit that they face it only with difficulty. Instead, they spend time and effort creating illusions and pretending that it could never happen to them. Even the insurance men who make a living penetrating the pretense, do it with euphemisms such as "estate planning," "life insurance," and "security against the unexpected eventualities of life."

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[4]Robert E. Kavanaugh, Facing Death (Harmondsworth, England: Penquin, 1972), pp. 3-8

When effective communication breaks down, the end result is depression, undiffused anxiety, and the creating of illusions. None of these helps a person meet a real crisis. Rather, they make the person particularly vulnerable to the one thing that marks man as mortal, the need to contend openly and honestly with the face of his own and other people's death[5]

The emotions are so intensified that they cannot be faced. Free-floating anxiety takes their place and is passed on to children who have little or no protection against it. The fear of death that once through open confrontation led to medical research, agricultural advancement, and architectural improvement, now seems often to be replaced by a nameless, faceless anxiety about death that constricts the creative processes of research. Even in medical circles death and dying are evaded as essential aspects of human existence, and the causes of death are identified not as normal but as accidental. So medical language is weighted by terms like "cerebral accident," cardiovascular accident," and "circulatory accident."[6]

This, then is the cultural state in which we must begin to think of society and the dying person.

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[5]Margaretta K. Bowers, Counseling the Dying (New York: Aronson, 1975), pp. 53-55.

[6]Edgar N. Jackson, You and Your Grief (New York: Channel Press, 1961), p. 94.

2. How it Affects the Family and Friends

We begin with a problem of language and not the semantic terminology but rather the concept. The basic problem, is a denial of death, as I mentioned earlier, in terms of "separation."[7] The effect of this attitude of denial creates in the remaining period of time, for the dying person and the family and friends a basic deception. The remaining unfinished business of life, for all persons becomes distorted by the systems that set in to protect, rather than deal with the real agenda.

Our society has set up systems which not only do not deal with the reality of death, but rather plant seeds of misrepresentation which become almost immovable. It is not acceptable in current thought to present all materials to the dying person. Yet, the truth that is being requested is a growing truth that will in turn change society's attitudes. Research of our present institutional programs dealing with the various phases of this all important matter show that the approach is generally custodial,

The isolation of the dying person, separated from family, friends, and community is the initial part of the latter separation in death. The effect upon the dying person is an entire composition of rejection, suspicion and denial not truly necessary, but well founded by the presented

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[7]Hinton, pp. 130-132.

atmosphere.

The two institutions that are assigned the responsibility of providing the custodial care, are the hospital and the convalescent home. Later in my project, I shall share materials and ideas as developed in the Hospice program and its approach.

Our very problem of denial returns once again to be the basic source of much of our problem. The laws of euthanasia, malpractice,[8] economic pressures all cloud some of the moral issues with which we are confronted. The latter question of morality is truly basic to the concern of the rights or privacy, self-determination and the acceptance that death is part of life and as good as life. Yet, the institutions are assigned the responsibility of shielding us from certain accepted realities and how they affect the persons involved, the dying person, the family and friends.

Until rather recently the very architecture of hospital buildings declared their attitude to the entire subject.[9]

Built in such a way the the most removed rooms, least attended, were those to which terminally ill persons were assigned. This physical arrangement, even set a tone of custodial care where the nurses could be replaced by

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[8]Marvin Kohl, The Morality of Killing (New York: Humanities Press, 1974), pp. 26-27.

[9]Hinton, pp. 149-150.

aides or the patient was just disregarded. Often, it was explained by a series of rationalizations such as, given the number of patients and staff it would seem better to give more attention to those who could recuperate.

C. THE HOSPITAL

Going into a hospital with little hope of coming out alive means that, alongside freedom, some remaining life is taken away. It is a bit of dying; some things will be left for always. The familiar life is over; the presence of loved people will now be rationed. Even if there is no human company to leave at home, the heartbreak and anxiety at leaving a pet who has been life's sole remaining companion should not be underestimated. The understanding doctor will not take lightly the decision to advise his patient to go to the hospital to die; the emotional needs should not be unnecessarily subordinated to the requirements of physical care. Herein rests a basic part of the issue as it regards the hospital and convalescent home.

The problem of meeting the emotional needs in the institutional setting require recognition that the dying person, family and friends are all in need of special emotional care above and beyond the ordinary situation.[10] This is not only a matter of sufficient staff, but trained personnel capable of handling a matter of such importance.

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[10]Ibid., p. 153.

This becomes a matter of special training, and such persons must be very selectively chosen for this work. The usual hospital and convalescent home is at best dealing with the problem of adequate help its medical needs require. This latter ingredient of special emotional sensitivity is a more rare trait which can be enriched through training, but not readily available. The problem of care in terms of physical needs and the type and amount of medicine to keep the pain level under control still needs to deal with emotional problems reserved for this special group of persons, namely, the dying person, the relatives and friends.

For various reasons one person in two does not end life at home. Some, because their treatment needs can only be met in a hospital; some, because the available home care is too scanty, and some because they enter the hospital for investigation or treatment, and never improve enough to leave. The differing kinds of standards of hospitals in which they die vary as much as do their homes.[11] The range of hospitals includes homes specifically for the dying, hospitals and institutions for the chronically ill, homes for the aged, nursing homes and convalescent care homes.

D. THE CONVALESCENT HOME

Some of the homes for the dying are good.[12] The familiarity of the staff with death by no means diminishes

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[11] Ibid., p. 160

[12] Ibid., p. 140.

their individual kindness or the degree to skilled attention they give to people who have little life left. Their morale and devotion is high and their experiences enhance their service. Many are affiliated with a religious organization which inspires their vocation. Considering their circumstances, patients in well-run homes for the dying are often able to enjoy some of their remaining days in remarkable peace and acceptance. Their worst moments are possibly those soon after arrival, especially if they come, trusting in people who have said they were to have a period of convalescence or new treatment, only to discover that they have been sent to the hospital to die. Herein lies that amount of truth, of which I previously spoke. In the main, however, the realization that they actually are dying grows more gently in the company of those who also face fate with courage. The relatives and friends who visit them are glad to see their dignity and comfort restored, when formerly they have seen them frightened and suffering.

Hospitals and convalescent homes need a high standard of personal integrity and morale among a staff adequate in numbers, and equipped with enough material facilities, if they are not to degenerate.[13] To be admitted to an overcrowded, poorly maintained ward containing many dying people can be no kindness to a person who retains all his normal

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[13]Norman L. Farberow and Edwin S. Shneidman, The Cry for Help (New York: McGraw Hill, 1961), pp. 70-71

alertness. If around him he sees gloomy buildings, discontented staff and troubled people, he will soon become equally troubled. Such hospitals and convalescent homes can be improved. Expenditure on practical design and more attractive decor, making them better places to be in, can lift the spirits of staff and patients. A link with another hospital treating recoverable illness may be a help.[14] It will allow an interchange of ideas and new knowledge, and if any treatment is needed, this can be carried out in the allied hospital. The patients appreciate this chance for active care, knowing that necessary treatments will be given and that no remedies will go by default.

Many deaths take place in hospitals designed for the care of acute cases. In these centers are gathered much scientific apparatus designed to help in the diagnosis and treatment of remediable conditions. Sometimes the highly skilled staff are able to rescue from death people abruptly threatened by various medical or surgical catastrophies.

The problem of hospitals and convalescent homes is that there is a preference for treating the younger patient, where all feel rewarded if he is discharged fully fit. There is also likely to be a disproportionate interest in the rare and unusual case. This being so, it implies a real reluctance to care for elderly people who are unlikely to recover. They may well linger awhile in the hospital, until

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[14]Ibid., p. 96.

they die or are transferred elsewhere.[15]

The care necessary for treating dying people may not be at its best in hospitals catering to acute cases. The traditional design of large wards with a few single or double rooms does not allow much flexibility in the choice of a suitable bed for the dying; a sudden transfer of a person with deteriorating health from a full ward to a lonely side-ward is not always suitable. A very sick patient, unconscious or noisy and confused for days, may upset other people. A fully conscious person in his terminal illness sometimes may not feel at ease in a large ward because he just wants the quiet company of his relatives alongisde the bed without their feeling that they are in the way.[16] Besides the material shortage of suitable wards in an acute hospital, there is often not the psychological preparedness to care for them as aforementioned. Some of the staff are humane and excellent at this, of course, but some are less good. Owing to their own particular approach to medicine, and their awareness of the acute needs of the curable patients, they can be half-hearted in seeing to the welfare of the dying. Although those who die in acute care facilities will have available a number of palliative or potentially curative treatments, and so will not experience the grosser forms of neglect that other dying people may suffer, they may feel less important

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[15]Robert Kastenbaum and R. B. Aisenberg, The Psychology of Death (New York: Springer, 1972), p. 134.

[16]James Agee, A Death in the Family (New York: McDowell-Oblensky, 1938), p. 41.

in the eyes of the staff than they might.

Most people who do not die at home, die in hospitals or institutions such as convalescent homes. In fact, those to be considered as "chronically sick" euphemistically include people with fatal cancer and other conditions. What are the hospitals for the chronically sick like? Many are outdated institutions taken over as hospitals. In the last few years a great amount of money has been spent on building new ones, a private business venture.[17] A start has been made in the new buildings and selecting more staff who have both interest and training in treating chronically ill, aged or dying people. More nurses are needed, more physicians interested in geriatric problems, more social workers, physiotherapists, occupational therapists and so on. Such trained staff can alleviate the physical discomfort of patients with terminal illness and they can hope to make patients' remaining days more than just a period of awaiting death.

Our problem is not only the state of affairs of our American society in the denial of death, but it clearly deals with the persons involved, from the dying person to the person whose function it is to do the most menial task to meet the patients' needs at his home, hospital or convalescent home. The problem is, attempting to answer these

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[17] Milton D. Heifetz, The Right to Die (New York: Putnam, 1975) pp. 144-145.

needs in the most meaningful way. The next three sections of this project will attempt to offer knowledge and solutions to the problems presented.

CHAPTER III

TREATMENT OF THE DYING PERSON

Within the presentation of the statement of the problem, we have been alerted to the problems of facility and the dying person who lives within that facility. Our concerns also speak to the institution and its attitudes about the family and friends.

The history of how people were treated is one that is filled with horror stories in many cases. In others, there is a kind of token concern, and yet in some few, money was capable of purchasing good nursing care and facilities. The latter was reserved for the select few who were financially capable and willing to use these facilities and hire these staff persons.

The following represents a synopsis of what was transpiring up until recent days, and still is to be found in many communities throughout the country. Many of these institutions are unsuited to function as modern hospitals or convalescent homes.

They are often large, cold, damp buildings with no easy access from one part to another, so that it is difficult to get warm meals to the bedside and any equipment into the ward. The absence of elevators means that some patients, once upstairs, stay there until there is the

awkward task of getting their bodies down again at the time of death. There are large wards with four rows of beds running down their length, cold corridors, angled staircases and passages too narrow for wheelchairs. The sanitary arrangements are appalling, perhaps because when the hospitals and convalescent home were built, it was assumed that patients remained in bed, unable to use lavatories. Even this does not explain the deficiencies in sanitation; although bed-pans might be a dominant feature in institutions where patients were expected to be bed-ridden, there were no adequate facilities for cleaning them. We find hospitals where bed-pans are washed after use in an available lavatory, using a pot of water as there is no immediate supply of running water; they might be washed in the same room as the dishes and stored in the bath overnight. Bags of dirty linen rest outside the wards at the foot of stairways and spread their smell throughout the building. The dead cannot voice the negligence they have experienced.

When we inspect the hospitals and convalescent homes for terminal care we find sad or enraging deficiencies.[1] We are unlikely to find a universal solution to the problems of caring for the dying. Some needs will be met by the undramatic moves of making continued improvements in all the present services, eliminating the most obvious failings and

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[1]Barney G. Glaser and Anselm L. Strauss, Awareness of Dying (Chicago: Aldine, 1965), p. 148.

and raising the standards that are low. Glaser and Strauss propose that the system needs radical reform so as to keep the best of the existing methods of care, in addition to providing new facilities, but all of them having a different and an improved organization. Their more immediate recommendations are to improve training in terminal care in nursing and medical schools. At the same time the social and psychological aspects of the care of dying people need open review, rather than being kept at a level of personal institution among each group of staff concerned. They suggest that organization of terminal care needs to be planned to deal more rationally with individuals likely to follow a course taking them in and out of hospitals. Lastly, they recommend public discussion on the issues of terminal care which cannot be resolved solely by professional groups. Indeed, to organize and finance the far-reaching improvements they propose demands that people do face with wider understanding the problems of the dying, their relatives and friends.[2]

As with the strategy necessary to improve the services, a greater readiness to confront the problems of dying is required for the individual's care. Owing to uncertainty of any individual's terminal illness, and the general reluctance to consider the matter at all, the treatment of the terminally ill often drifts along until some crisis

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[2]Ibid., p. 172.

occurs. Then, owing to the lack of forethought, and no preliminary discussion between those concerned, hurried measures are taken. It often means accepting an inferior method of care of the patient because a more suitable alternative is not immediately available.

If the dying person himself cannot make clear his preference for future care, then someone else must make a judgment for him. Among those who do care for the dying person, be they relative, friend, nurse, clergyperson, social worker, family doctor, etc., there is usually one person who has sufficient knowledge of the dying individual and his condition to assume enough responsibility to plan the best course of care.

The possible benefits of an extension of limited hospital function has been confirmed in programs of home care based on hospital departments. In such arrangements the patients gain from the flexible operation of a team of various medical and social workers. They are prepared to treat people with terminal illness by arranging transportation to the out-patient department or by visiting them at their homes. Minor surgical procedures which relieve symptoms, such as draining accumulations of fluid from the body, are carried out if necessary. The enthusiasm and interest shown by the medical team is further reinforced by the echoing spirit of other agencies, nursing services and not least, the patients' families. With the guidance and moral support which the relatives receive, they can take over

quite skilled tasks of nursing, a great help to others and to themselves. Perhaps, toward the end, the attention needed by the patient increases so much that it is simpler for him to enter the hospital, but the dying person's preference for staying at home has to be taken into account. Although home care is not ideal for all patients - it depends on their own condition and that of their families and households - much can be achieved. It has been shown that when people take a positive interest in the welfare of the dying, their last days on earth need not be problematic.[3]

Modern treatment of the dying person has been pioneered by a number of persons. The three persons whom I believe have made some of the most meaningful contributions are: Cecily Saunders, Elisabeth Kübler-Ross and Edwin Shneidman. The findings of Saunders gave birth to the Hospice program which I will discuss in my next section. The work of Shneidman was primarily in two main areas, suicide prevention and psychological autopsy. Kübler-Ross did the most intensive amount of work with the dying person. Her studies provide us with an understanding of the various phases of dying for the dying person as well as relatives and friends. This knowledge assists us in dealing with these persons and understanding their needs. This latter

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[3]Henry K. Beecher, "Ethical Problems Created by the Hopelessly Unconscious Patient," New England Journal of Medicine, CCLXXVlll (June 1968), 1425-1430.

understanding, namely needs, makes it possible in light of modern treatment to humanistically address ourselves to keeping proper perspective to the stages as presented by Kübler-Ross.

A. THE ATTITUDES OF ELISABETH KUBLER-ROSS

Kübler-Ross has added new dimensions to the field of death and dying; "my specialty is caring for people beyond medical help."[4]

In 1966, she visited a 600-bed hospital, spoke to staff members of her research project and was met with the comment, "we have no dying here."[5] She sought out a sickly-looking patient, sat down to talk and learned that no one would hear him; none would allow him to express his anger, grief, sadness about dying.

Kübler Ross listened, and the patient died shortly, having "finished his business" -- not of wills or inheritances, but rather the sharing of deep feelings, fear, love, regrets, unfulfilled dreams and expectations.

People need to say these things. People beyond medical help know they are dying; it is up to us, the living, who are unwilling to accept those facts, therefore we use

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[4]Elisabeth Kübler-Ross, "The dying Patient as Teacher: An Experiment and an Experience," Chicago Theological Seminary Register, LVll: 3 (1966), 22-23.

[5]Ibid., p. 29.

denial and avoidance to protect ourselves.

Such inappropriate behavior of staff members in these institutions created her determination to teach people -- those treating the dying and the dying themselves -- how to deal with death and dying.

One result, is that the dying who shared intimate feelings had less problems with themselves and their family, and died peacefully.

Kübler-Ross emphasized the need of staff personnel to HEAR the words of their patients, or to listen for symbolic meanings, for clues. To locate the clues means more contact, a task invariably falling upon the nurse or the aide.[6]

A gentle touch, a hand held, a ready ear, a few shared private moments alone with interruption means more than crisp sheets or manners; the patients want messages saying they are noticed and they will be missed. Nursing schools encourage the denial system; they teach prospective nurses to avoid the feelings people bring up when meeting death, and not to touch emotionally, and consequently, patients are dehumanized as a result of a lack of "touching" and sharing and caring from the nursing staff.

The patient reaction is geared to soliciting those "care" messages.

How can we help: The real problem, writes Kübler-

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[6]Elisabeth Kübler-Ross, On Death and Dying (New York: Macmillan, 1969), pp. 17-22.

Ross, is "how to let them know we know, since they all do."[7]

She believes the patients want most of all not to be left alone, unless they ask to be.

The staff can admit their honest "gut reactions" and acknowledge feelings of sympathy, anger, sadness, unfairness, helplessness, frustration, hopelessness and inadequacy.

Seventy-five percent of the terminally ill die lonely, isolated, feeling responsible, feeling guilty... "these people are in a nightmare situation, thinking they are causing these feelings in other."

One who asks the question, "What is your fear?"[8] and answers it will be coming to grips with death. Is that fear of pain? Lack of dignity? Machine existence? Punishment? Leaving children? Husband's or wife's remarriage? Parents guilt? Mourning of loved ones? Expressions of condolences to survivors?

Those patients who don't talk about dying are the ones who need help the most since they are protecting the living from their dying.

Since a person's acceptance changes daily, and is dependent on their stage of acceptance (the stages of death include denial, "why me," to anger and bargaining with God), the less one knows of the patient's state of mind and feelings, the more one is required to listen for the inevitable

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[7]Ibid., pp. 33-35

[8]Ibid., pp. 50-54

clues they give out.

One paramount concern is to not prevent the fear of the patient about sharing the intimacy of death. The most important thing to do is to listen. Patients know who is ready to hear them, who is up-tight or has a hang-up about death.

Children have been known to hang onto life for weeks to ease their parents' anxiety about death. Many of the dying pass away without sharing the intimacy of death -- since the parting comment to them was a joke, a quip or the message like, "now you get better real soon. Try hard."[9]

The patient picks a "love substitute," usually a nurse or an aide.

If a patient does not talk, nod, draw or express, allow them that privacy. They also need permission to cry and to allow others to cry.

Dying people need someone who cares, not just a person who takes care of them.

In interacting with the family of the dying, there is a difference, it is normal for an outsider to be more objective, to be a better listener -- and the family can learn from the outsider, not emotionally involved.

Most of what we do is to satisfy our own need. If in doubt of what we are doing, we need only to ask the dying;

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[9]Elisabeth Kübler Ross, Questions and Answers on Death and Dying (New York: Macmillan, 1974), pp. 170-171.

they know the answers.

Allowing the dying to wrap up "unfinished business" is one important need.

To give the gift of privacy to a patient is paramount and the dying need time along with significant people in their lives -- without the usual interruptions of hospital and convalescent home procedures.

To escape their plight, the dying have few choices, among them suicide, psychosis, homicide.

But when nobody wants a sick person, what happens?

Even when a person seems psychologically dead, most can still hear, perceive what is happening around them, Kübler-Ross tells us, "For the patient, the hearing about charts, statistics, coupled with painful tests, probings, unnecessary moving around; x-rays, another chemotherapeutic poisoning, heightens the agony."[10]

Dying persons progress through the same stages accompanying a loss such as of a limb, breast, mate, marriage, child, job, home, even a pet. Kübler Ross said the stages are real, that we need to learn to accept people in whatever stage they are, and not push them forward into another level to fulfill our own needs.

To die with dignity is to die with character, one's own character, whatever that may be.

Kübler-Ross makes the following observations.

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[10]Ibid., pp. 44-46

Hope[11]-- ....different stages that people go through when they are faced with tragic news - defense mechanisms in psychiatric terms, coping mechanisms to deal with extremely difficult situations. These means will last for different periods of time and will replace each other or exist at times side by side. The one thing that usually persists through all these stages is hope. Just as children in Barracks L 318 and L 417 in the concentration camp of Terezin maintained their hope years ago, although out of a total of about 15,000 children under fifteen years of age only around 100 came out of it alive.

> The sun has made a veil of gold
> So lively that my body aches
> Above the heavens shriek with blue
> Convinced I've smiled by some mistake.
> The world's abloom and seems to smile.
> I want to fly but where, how high?
> If in barbed wire, things can bloom
> Why couldn't I? I will not die![12]

In listening to our terminally ill patients we were always impressed that even the most accepting, the most realistic patients left the possibility open for some hope, for the discovery of a new drug or the "last-minute success in a research project."

Kübler-Ross was able to place in some form of meaningful order the transitory stages of the terminally ill patient as well as those who are involved in the process of

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[11]Kübler-Ross, On Death and Dying, p. 138.

[12]Ibid., p. 139. "On a Sunday Evening," (Anon. 1944).

death, such as family, friends, medical staff and clergy. This major contribution helps us to better understand the stages of development and the frame of reference of all involved persons.

The stages of dying as charted by Kübler-Ross are as follows:

Denial..[13] Denial following the presentation of a diagnosis is more typical of the patient who is informed prematurely or abruptly by someone who does not know the patient well or does it quickly "to get it over with" without taking the patient's readiness into consideration. "This is a common device used by most patients during the first stages of illness and their confrontation with it, and may be used temporarily from time to time as the illness progresses."

Defense mechanisms--Denial is usually the first form of defense against the indefensible. Generally though it is temporary as the patient goes into the succeeding stages of transition to final acceptance. Maintained denial is rare and does not always bring increased distress. Kübler-Ross encountered only three patients among two-hundred terminally ill who attempted to deny death till the end. Two of the three talked briefly about dying but only referred to it as "an inevitable nuisance which hopefully comes during sleep"

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[13]Ibid., p. 39.

and said, "I hope it comes without pain." After their brief moment of acceptance, they reverted back to the defense mechanism of denial.

Most patients though, do not maintain the denial defense. They frequently will talk briefly about the reality of their situation, and as frequently will indicate an inability to continue to face the reality. The indication that a patient is no longer able to face the facts is generally illustrated by his discussion of his life, whatever relevance he may feel about his life and how he has lived, and he may also fantasize about death itself as well as life after death, (which in itself is a form of denial.) It is not unusual in this form of defense mechanism to have the patient change the topic, almost in contradiction of his earlier statements.

Mortality--After the first stages of denial and defense the patient may start to recover from the initial shock only to find himself faced with his own mortality. As his initial feelings of numbness start to pass, and he begins to collect himself, he must face the fact that he is indeed mortal. Man's usual response is "no, it cannot be me." In our unconscious mind death comes to someone else, or is far off in the dim future and it is inconceivable to most of us that death comes to us "now"; we must face it "now"; it is not happening to someone else. We are not immortal.

According to Kübler-Ross's study, how a patient is told, how much time he has to assimilate the knowledge, and the acceptance of that knowledge, whether he has learned to cope successfully with situations are the determinats as to how soon and how well he will discard the defense mechanisms and accept the inevitable through less radical means of defense.

Reaction Response to Outside Attitudes and Influences --Kübler-Ross further found a reaction response among patients who have used denial when faced with hospital staff members who had to use this form of coping for their own reasons. Such patients can be quite selective in choosing different people among family members or staff with whom they discuss matters of their illness or impending death while pretending to get well with those who cannot tolerate the thought of their demise. It is possible that this is the reason for the discrepancy of opinions in regard of the patient's needs to know about a fatal illness.

Anger[14]--Anger is generally the next stage when denial can no longer be maintained, the defense mechanism of the different forms of denial and fantasy are put aside, and mortality has been accepted. All of the previous feelings are replaced by subsequent feelings of rage, anger, envy and resentment. In contrast to the other stages, this

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[14]Ibid., pp. 50-51.

stage is very difficult to cope with since it encompasses all of the other stages while bringing in new elements. The anger is displaced in all directions and projected on anyone and anything in the patients environment, frequently it appears to be projected at random. The doctors may be attacked as inefficient or ignorant or ineffectual. They don't know what diet to prescribe. They keep the patients too long in the hospital or don't respect their wishes in regards to special privileges. They allow a miserably sick roommate to be brought into their room when the patient pays so much money for some privacy and rest, etc. The nurses are even more often a target of their anger. Whatever they touch is not right. The moment they have left the room, the bell rings. The light is on the very minute they start their report for the next shift of nurses. When they do shake the pillows and straighten out the bed, they are blamed for never leaving the patients alone. When they do leave the patients alone, the light goes on with request to have the bed arranged more comfortably. The visiting family is received with little cheerfulness and anticipation, which makes the encounter a painful event. The family then either respond with grief and tears, guilt or shame, or avoid future visits, which only increases the patient's discomfort and anger. It is very difficult to cope with this kind of attitude. Few of us are able to project ourselves into this type of situation since this goes back to the question of mortality. We too see ourselves as immortal. It is difficult to understand

and accept the anger and recognize from whence it comes and how it comes about. How many of us can project the feelings of anger we might possess, if our lives activities were to be interrupted prematurely.

Bargaining[15]--A very common method of defense employed by most terminally ill patients is to try plea-bargaining with God. If we have not been able to accept the unacceptable in the first place, if we have been forced to accept our own mortality, if we have displaced our anger at our own mortality, if we have displaced our anger at our own mortality at family, friends, doctors, nurses, other staff people, even God himself, and it didn't change the fact, perhaps we can plea bargain with God and possibly postpone the inevitable. "If God has decided to take us from this earth, and He did not respond to my angry pleas, He may be more favorable if I ask nicely." And so the terminally ill patient may try to strike a bargain with God; "if you will do this for me ---" He knows, from past experience, that there is a slim chance that he may be rewarded for good behavior and be granted a wish for special services. His wish is most always an extension of life, followed by the wish for a few days without pain or physical discomfort. A patient who was an opera singer, with a distorting malignancy of her jaw and face who could no longer perform on stage,

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[15]Ibid., pp. 82-84.

asked "to perform just one more time." When she became aware that this was impossible, she gave the most touching performance perhaps of her lifetime. She asked to come to the seminar and to speak in front of the audience, not behind a one-way mirror. She unfolded her life story, her success, and her tragedy in front of the class until a telephone call summoned her to return to her room. Doctor and dentist were ready to pull all her teeth in order to proceed with the radiation treatment. She had asked to sing once more-to us-before she had to hide her face forever.

The bargaining is really an attempt to postpone; it has to include a prize offered "for good behavior," it also sets a self-imposed "deadline" (e.g., one more performance, the son's wedding, and it includes an implicit promise that the patient will not ask for more if this one postponement is granted. None of our patients have "kept their promise"; in other words, they are like children who say, "I will never fight with my sister again if you let me go."

Depression[16]--One of the final stages a terminally ill patient undergoes is acute depression. When he is no longer able to deny, when he is forced to undergo more surgery, more hospitalization, additional symptoms, increased weakness, loss of weight, he can no longer smile it off, or deny the truth. He must face the fact of his approaching end. His numbness, rage, stoicism, bargaining with God

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[16]Ibid., pp. 85-88

attitude is gradually replaced by an overwhelming depression and sense of great loss. Added to the physical symptoms are the very real financial and personal burdens of money and family responsibilities.

With the extensive treatment and hospitalization, financial burdens are added; little luxuries at first and necessities later on may not be afforded anymore. The immense sums that such treatments and hospitalizations cost in recent years have forced many patients to sell the only possessions they had; they were unable to keep a house which they built for their old age, unable to send a child through college, and unable perhaps to make many dreams come true.

There may be added loss of a job due to many absences or the inability to function, and mothers and wives may have to become the breadwinners, thus depriving the children of attention they previously had. When mothers are sick, the little ones may have to be boarded out, adding to the sadness and guilt of the patient.

Kübler-Ross had noted that all of these reasons for depressions are well known to everybody. When the depression is a tool to prepare for the impending loss of all the love objects, in order to facilitate the state of acceptance, then encouragements and reassurances are not as meaningful. The patient should not be encouraged to look at the sunny side of things, as this would mean he should not contemplate his impending death. It would be contradicting to tell him not

to be sad, since all of us are tremendously sad when we lose one beloved person. The patient is in the process of losing everything and everybody he loves. If he is allowed to express his sorrow he will find a final acceptance much easier, and he will be grateful to those who can sit with him during his state of depression without constantly telling him not to be sad. This second type of depression is usually a silent one in contrast to the first type, during which the patient has much to share and requires many verbal interactions and often active interventions on the part of people in many disciplines. In the preparatory grief there is no or little need for words. It is much more a feeling that can be mutually expressed and is often done better with a touch of a hand, a stroking of the hair, or just a silent sitting together. This is the time when the patient may just ask for a prayer, when he begins to occupy himself with things ahead rather than behind. It is a time when too much interference from visitors who try to cheer him up hinders his emotional preparation rather than enhances it.

The final stage in Kübler-Ross's stages of development is that of acceptance...[17] This stage should not be mistaken for a happy one, or even a time of contentment. It is just acceptance of that which is-that which we cannot change or postpone. It is a time almost void of feelings. It is as if the pain is gone, the struggle is over,

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[17] Ibid., pp. 113-114

acceptance has come and the time is that of, "the final rest before the long journey," as one patient phrased it.

Family--Now that the patient has found some acceptance and a medium of peace the needs of the family must be met and faced. This is the time when the family requires a maximum of help, support and understanding. Quite possibly, the needs of the family at this time exceed that of the patient. As the patient learns to accept the inevitability of his fate, as he finds a degree of peace within himself, his circle of interest tends to diminish, to be reduced to himself and his fate. He frequently will prefer to be left alone in solitude. The problems outside his own immediate needs are of little or no interest to him. His world has shrunk to the size of his own immediate being. Visitors are frequently not welcome and if they do come, the patient may well not wish to have them intrude into his private world.

The aforementioned are excerpts from the basic material which Kübler-Ross then illustrates with case studies.

As the patient goes through the various stages from denial to acceptance to yet hope, we need to be sensitized to a number of special needs. The patient is emotional and whether he is rational or irrational the understanding and tolerance expected of those who attend to the patient, family and friends needs to be paramount. The brief statement is evidenced in all of the meaningful studies done by Kübler-Ross and Shneidman. The most modern treatment

underscores these special sensitivities in both verbal and non-verbal communication. What has been learned about needs is that the kind of human attention given beyond the physical concerns is most significant.

THE ATTITUDES OF EDWIN SHNEIDMAN

Shneidman brings other elements to our understanding of the treatment of the dying person. The materials that are most unique is one which reflects upon cultural attitudes and patterns. As we live in a death denying society, so too does our society support the taboos about death. Shneidman's most unique contribution is called the Psychological Autopsy. The purpose of this device is to let us understand not only beyond the physical, namely, the psychological cause of death, but most important the proper treatment of persons who died suicidally or geriatrically or because of terminal illness.

Shneidman, Professor of Medical Psychology and Director of a Laboratory for the Study of Life-Threatening Behavior at UCLA, is the authority with whom I concern myself at this time.

Clearly, Shneidman underscores the fact that death has become less and less the taboo topic it used to be. The clinical details of inevitable death are important, as well as with the surviving "other." The main thrust of his studies is an examination of the actual dying process and, equally significant, the stress in which a person is placed

as the bonds of life let loose. The quality of this transition has significant religious overtones as the question of mortality becomes significant to understanding the relationship.

The importance is "post-vention,"[18] namely, working with the survivors after the death of a loved one. This is part of the necessary care required in the work of Shneidman.

Among the various major contributions that Shneidman has presented to the world of thanatology is his understanding of "subintention," a state of mind which leads the patient to play a role in hastening his own demise. A second significant contribution is "ambivalende,"[19] a state of mind in which a person moves toward sustaining his life.

Probably one of the most significant aspects of his work deals with the aforementioned psychological autopsy.[20] Through this method a meaningful understanding by the health team can attempt to recreate the life and life-style of the deceased. In a psychological autopsy or post-mortem examination, the study of the psychology of death, dying, life threatening behavior, all begins to unravel itself. In a multi-disciplinary spirit, the involvement of social and behavioral sciences merge together to create a new understanding of life; motivations, intentions, attitudes, and the total person, as a totality.

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[18]Edwin S. Shneidman, Deaths of Man (New York: Quadrangle-New York Times, 1973), pp. 43-47.

[19]Ibid., pp. 81-83.

[20]Ibid., pp. 131-136.

Every question affecting mankind involves death. It is an answer to many of the ultimate questions that most people find hard to formulate. Our cultural heritage has given us methods to deny, omanticize and placate death -- Shneidman has attempted to give understanding and meaning to this process.

It is most interesting that, like most human beings, physicians and other members of the health professions, "healers," are afraid of death. It is, therefore, significant that one can isolate physical factors in death from the personal and, thereby, give meaning to both of these important areas. The personal behavior, relationships, economic status, emotional style, etc., understanding the essence of the person, what remains in terms of the post-organic are essential for understanding. What a person died from and not what he lived for, becomes the essence of our concern. How he managed to live in the midst of turbulent and difficult times is insignificant to the health team and the parameters of scientific knowledge.

If, indeed, specialist always talk in strange tongues, especially to each other, the laity like to hear words that they can comprehend. Shneidman present this kind of efficient meaning

Psychological Autopsy

1. Identifying information for victim (namely, age, address, marital status, religious practices, occupation and other details).

2. Details of the death (including cause, method, and other pertinent details).
3. Brief outline of victim's history (siblings, marriage, illness, medical treatment, psychiatric treatment, previous attempts).
4. "Death history" of victim's family (suicides, fatal ilnesses, ages at death, other details).
5. Personality and life-style of victim.
6. Victim's typical reactions to stress, emotional upsets, and period of disequilibrium.
7. Any recent -- last days to twelve months -- upsets, pressures, tensions, or anticipation of trouble.
8. Role of alcohol and drugs in life-style and death of victim.
9. Victim's relationships with others, including physicians.
10. Fantasies, dreams, ideas, premonitions or fears regarding death, accidents, or suicide.
11. Changes in victim before death (habits, hobbies, sexual patterns, life routines).
12. Information relating to "life-side" (upswings, plans, success).
13. Assessment of intentions, i.e., role of victim in his/her own demise.
14. Rating of lethality.
15. Reaction of informants to victim's death.
16. Comments, special features, etc.[21]

Geriatric Autopsy

A variation of this type of autopsy is the one prepared specifically as a geriatric version.[22] This gives us some true understanding of the type of meaningful treatment the person could receive.

Realization of Death

1. Final Illness

1. What was the patient's terminal illness?
2. Did this illness differ substantially from admission diagnosis?

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[21]Ibid., pp. 137-138. [22]Ibid., pp. 147-150.

3. Was the death expected or unexpected at this time? Why?
4. Was the death sudden or gradual?
5. Was autopsy permission granted? By whom?

II. Preterminal Period
1. What was the mental status and level of consciousness prior to the terminal illness?
2. What drew attention to mental, physical, or social changes?
3. What references did the patient make to death, dying, or decline.
4. Were there any indirect indications of impending death?
5. What were the patient's relationships during this period?

III. Hospital Course
1. What were the extent and nature of patient's relationships - staff, other patients, family, visitors, etc. - during the overall course?
2. How was the patient regarded by those in closest contact?
3. What personal problems or crises developed and how were they met?

IV. Prehospital Situation
1. What was the patient's medical and mental status at the time of admission?
2. What medical, social, and personal circumstances led to hospitalization?
3. What was the patient's attitude toward admission?

Says Shneidman: My own limited work has not led me to conclusions identical with those of Kübler-Ross. Indeed, while I have seen in dying persons isolation, envy, bargaining, depression, and acceptance, I do not believe that these are necessarily "stages" of the dying process, and I am not at all convinced that they are lived through in that order, or, for that matter, in any universal order. What I do see is a complicated clustering of intellectual and affective states, some fleeting, lasting for a moment or a day or a week, set, not unexpectedly, against the backdrop of that persons total personality, his "philosophy of life" (whether

an essential optimism and gratitude to life or a pervasive pessimism and dour or suspicious orientation to life.)[23]

This treatment or analysis of the person who has died gives us an understanding as to his needs during his lifetime. This insight also tells us about the effective or uneffective way he was dealt with during his final months/weeks and days as a dying person. Shneidman illustrates the effect of this method by offering a series of case studies. The following is but a sample example of this method in application (selected segments of the psychological autopsy.)[24]

"The victim was found dead in his burning apartment. He was burned over 80% of his body. Blood analysis showed Ethanol absent; 0.6 mg percent Secobarbital, and .009 mg. percent Amphetamines. 85 percent carbon monoxide saturation was found in the blood." The psychological autopsy revealed that the deceased was a 28 year old, unemployed male, who lived alone. One day prior to his death, his mother died after a lengthy bout with cancer. Further information revealed, that in addition to the shock of the loss of his mother, the young man, who had been unemployed for several months also faced financial disaster since he was supported by his mother. He had been living in virtual isolation for the past few months, socially isolated except for his daily visits to his dying mother in the hospital. In addition to

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[23]Ibid., p. 6. [24]Ibid., pp. 139-142.

all of this, the young man's long-term love relationships with others had been deteriorating.

The deceased turned out, on further examination, to have been a rather exceptional person. He, according to a close friend, possessed not only an IQ of over 180, but had the ability of total recall; that is, he could read a page once and repeat it verbatim, word for word. The young man was an avid reader of Austen and Dostoyevsky, as well as a lover of music. His friend stated that he had tried to help the young man to straighten out his life by introducing him to metaphysics.

The friend further stated that the young man's mother had a stranglehold on her son. She was a very difficult and tyrannical person, who made great demands on him, such as sending him out to buy puddings with a special sauce, and then when he brought it to her, refusing to eat it. She was difficult to please, but her son kept trying. He visited her daily in the hospital and was very dependent upon her as well as upon his friend, the young man Shneidman interviewed.

According to the friend, the deceased called him when his mother died. They went to the hospital together to make arrangements for the burial of the mother in another state. The deceased told his friend of his own desire to be cremated in accordance with his metaphysical beliefs.

With the death of his mother, the deceased, attempted to re-establish a relationship with a male friend now involved

with someone else. In desperation, the deceased went to the friend's apartment and created such a disturbance that the police were called. The young man was arrested and taken to jail.

At 11:00 p.m., on the same day the mother had died, another male friend was surprised to receive a call from the deceased asking him to bail him out of jail. The deceased told the friend, "I have no one else to call." The friend came and posted bail.

The day following all of these events, the deceased was supposed to bring some clothes to the mortuary for his mother's body. At 10:30 a.m., the friend called the deceased and reminded him. He stated later that the deceased was incoherent and appeared to be drunk.

Shneidman also interviewed a friend of the deceased's mother. She told him that she had met the deceased several years ago while taking an English class. At that time, she stated "he was a nice, bright, alert boy who was fun to be with." But as the years passed, according to the woman, the boy's personality changed and he became progressively worse, relying more and more on the use of amphetamines to carry him on.

About four days before his death, she saw the deceased. He appeared timid, was stammering in his speech and just sat in the chair without talking much. The day he died the deceased called her on the telephone. She had never heard him sound so upset. He was hysterical,

frightened and desperate. He told her he had no one to turn to and that he had never felt like this before. He seemed to be 'exploding' and begged her and her husband to come over. The deceased told her that the previous night he had taken several seconals and could not sleep. He stated he was disturbed about his relationship with his male friend, went to his house and pounded on the door begging to be let in but the police were called and he was taken to jail. 'Yes, I'm just like them.' She stated he was identifying himself with the Monroe-Garland deaths.

The woman further stated that she felt that the deceased was involved in a pattern of self-destruction. He appeared to be doing his all to bring about his own death wish, and she could not conceive of his living under these conditions indefinitely. He was 'worn down' according to her, and had greatly suffered as a result of the death of his mother, his feelings of rejection in relationship to her as well as the rejection by his lover. She also believed that "the boy's mother didn't want him to live after she died--that she wanted to take him with her." She thought that the deceased had shared the mother's casket on the trip to the burial.

To summarize the psychological profile, we find a 28 year old single male, dependent, despondent, unemployed, suffering terrible feelings of rejection, abandonment, panic and loneliness, feelings which multiplied under the double effect of his mother's death and his lover's involvement in

another love relationship. Although it appears that he may have been suicidal, evidence at the scene suggested that he died accidently as a result of a fire in his apartment. There was further evidence that the deceased appeared to have had a tantrum-like episode which consisted of his throwing things around his apartment. Apparently, following the temper-tantrum, he fell into an exhausted sleep. He had also ingested quantitites of secobarbital and amphetamines before the fire started.

"On the basis of the investigation -- both the psychological and physical aspects of this case -- it is recommended that the mode of death be certified as a Probable Accident."[25]

WHAT HAS BEEN LEARNED ABOUT NEED

In the segments of the case presented we can see certain patterns of need that express themselves. The use of this technique could well help deal with these needs at other times in another person's life. We are all patterns of a similar type unto each other.

The social scientists were able to point to the fact that the 28 year old had been suffering from depression since he learned of his mother's illness with cancer. He was going through the stages as previously presented. He was dependent upon his mother and others. This insecurity was part of a

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[25]Ibid., pp. 143-144.

character disorder and the loss of his mother was a depression and rejection he could not handle. The progressive qualities of depression became even worse as his mother's illness progressed. His fears, desperation and hysteria were all clues to what was happening to his progressive deterioration. The rejection from all sides was more than he could deal with. He found himself abandoned and alone. The psychological autopsy tells us that he was crying for help for a very long time. He was a dying person who was not being attended in terms of his needs. His life was death-oriented and his needs unattended.

The emotions aroused by death are many - fear, sorrow, anger, despair, resentment, resignation, defiance, pity, triumph, helplessness and, to some degree, practically any emotion that there is. The commonest one is fear. Sorrow is another important theme, felt when something worthwhile is lost, when a life is finished. Anger also keeps close company with death, both the anger that can culminate in killing and the resentment at death which takes away pleasure and promise.

Our psychological autopsy underscores the sense of need to speak to these emotions in the treatment of the dying person, the relatives and friends.

As a tool the psychological autopsy can strengthen the clergy to function more effectively. Relating to the needs of the dying now begins to surface in a very personal and direct way. If for example the available knowledge,

through the psychological autopsy would be known, then the clergy could take concerns in a specific direction. The dying parent and his relationship to spouse, children, family and community could be most effective and directive. The entire area of "unfinished business" could be greatly resolved through this technique. The greatest disadvantage to the clergy is the inability to deal closely in fine detail to the dying person. This method would provide the closeness so often lacking. It has always impressed me that the dying want to talk about a variety of subjects not mainly or only religion. The physchological autopsy opens up these possibilities. This new found strength then builds new bridges of relationships.

The physical and emotional discomfort that the dying are liable to suffer are implicit indications of the care that they require. Some of these needs are automatically recognized and met. It is only when the neglected patient is seen that one realizes how much of civilized care is taken for granted. A great deal is done to help the dying; so much, in fact, with so many variations according to individual requirements, that it is not feasible to attempt to condense all of the available knowledge. Aspects of physical and emotional care must be considered, keeping in mind especially the great importance that personal feelings have in the treatment of terminally ill people. The emphasis must always lie upon tending the person, treating the one

who feels symptoms, not just treating the symptoms.[26]

The physical methods of helping a dying person's discomfort are of the greatest importance and there are many excellent writings on these matters, but the incurable patient needs not only efficient practical care but faith in the judgement of those who must advise on his whole treatment program.

It is important for the patient to know that his doctor holds a sober balance between the need to investigate all aspects of a disease and the need to accept some illness as incurable. Occasionally a dying person will need the doctor to protect him from the zeal of his relatives who want to leave no possibility untried. It may be appropriate to explain to them that it is unnecessary, even unkind, to seek further to avoid the obvious conclusion that the patient cannot be cured. The anxieties of relatives should be helped so that they do not seek the outlet of fruitless medical activities or press for troublesome investigations and treatments which can do no good.[27]

The presence of affection, plus a sense of support, relate to the need of the dying person. This sense of trust in the kind of attention that is being given, the willingness

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[26]Edwin S. Shneidman, "Suicide, Lethality and the Psychological Autopsy," Aspects of Depression, International Psychiatry Clinics, VI: 2 (1970), 225-250.

[27]Glasser and Strauss, p. 86.

to accept discomfort rather than be drugged so that he can enjoy the visit of friends and relatives is vital.

Ill people gain help when someone simply pays attention to their complaints, even if they have described them several times before. Telling itself brings ease, and what is told will often indicate untried ways of bringing comfort.[28]

Reassurance comes to the dying if it is clearly demonstrated that nurses and doctors have every intention of controlling discomfort. For instance, if there is pain it should be clearly mastered. This is best done by regular doses of sufficient drugs given in good time before the discomfort returns. Then the ill person is not haunted by the thought that the pain may soon return requiring him to decide whether to hang on as long as possible or ask for relief with the first warning, the coming of which is awaited. To give drugs to patients with painful incurable diseases only when the pain gets bad, means that they are inevitably going to spend part of their day in pain, waiting for the next lot of drugs to work. When all severe pain is banished by regular repeated medicines, the troubled patient realizes that he will be able to face with some dignity the remaining portion of life: his returning courage will ease or even banish symptoms that formerly were so troublesome.

Besides the security of knowing that he will not be

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[28]Ibid., p. 97.

broken down by intolerable suffering, the dying person needs assurance that he can be adequately tended if he becomes quite weak or helpless.

If, together with adequate physical care, the dying person had sufficient human companionship, most of his anguish would be prevented. He wants to see and know that those about him still have a warm interest in him. Even if there is a painful recognition that his working life and consequent status among his fellows have come to an end, he wants to know that personal ties remain. Unfortunately, this is not always so, and a dying person can suffer from the impression that he is written off and already being forgotten. Occasionally a patient feels this so strongly that he may comment that people already seem to act as if he were dead. In pleasant company he is less likely to have his fears grow too big and overwhelming, apprehensions not only for himself but also for those he loves are diminished.

The relatives and friends of the dying patient may not be able to give the supportive companionship or nursing care that they would like to give if they themselves are troubled. They may need to cope with the situation and their own feelings.[29]

The dying person will often wish to prepare himself spiritually for approaching death and will need the rabbi, priest, or minister for this. In the religious faith of

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[29]Ibid., pp. 26-29

some dying people it is important for them to take a conscious part in a preparatory service.

The appendix can additionally be of assistance to the relatives and friends of the dying person as it addresses itself to the rituals and ceremonies and how they speak to our needs.

CHAPTER IV

THE ENVIRONMENT OF DYING

In the aforementioned sections of this project, I have been attempting to present those materials which place before us an understanding of the modern treatment and attitudes concerning the dying person, his relatives and friends. Clearly, the contemporary position grows from that of custodial care to one of serving a meaningful relationship in attempting to address the emotional needs of the important persons involved in the total event of death and dying.

It seems necessary at this point to make this statement, that no project can completely deal with all the ramifications, psychologically, sociologically, religiously and culturally since we are dealing with a problem which is deep-seated within the patterns of attitudes historically developed from the first encounter of man with death.

The works of the scholars in the field, all bring to our attention a greater need to attempt to understand how one can meaningfully deal with the treatment of the dying person. If, indeed, the modern treatment can be drawn to a symbolically high plateau, then this section which will present the work of Ceciley Saunders and St. Christopher's Hospice is but an example of modern thought and treatment

which can bring higher credibility to fulfilling the needs of the dying person, his relatives and friends.

THE HOSPICE

For those who are unfamiliar with the program, it seems that the best way to characterize it is that of taking a terminally ill person from the "death house" environment, and placing him into a setting of both mutual understanding and acceptance. The key to this program is the latter observation, namely mutual acceptance and programming.[1]

Within the parameters of ability of the National Health Program of England and private fundings, Saunders has been able to transplant, with the sensitivity of a personal touch, the custodial care of an institution into a sharing experience which usually relates itself to home care. It has been the experience of those who deal in the field of the dying patient, that the home environment is the most perfect, given all alternatives. The reality is that, within this frame of reference, the patient in Saunder's program is made to feel that the hospital center pulsates and functions as a "home" world.[2] The basic ingredients

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[1]Cicely Saunders, "The Last Stages of Life, American Journal of Nursing, (1965, 70.

[2]Cicely Saunders, Care of the Dying (London; Macmillan, 1959), pp. 41-49.

then, are the personal contact between patient and staff, and, most particularly, with the family. If the patient is bed-ridden, the bed becomes a vehicle as mobile as a wheel-chair. Within this context, each patient is capable of visiting and being visited. Since the frame of reference of the patient within the hospice is preparation for death, there is a common basis of understanding and relationship.

The difficulty with the program of Saunders is not the program, per se, but with those of us who have been non-objective regarding the area of death, being able to deal with the needs of the situation.

The essential ingredient that Saunders has injected into St. Christopher's Hospice is the work "Polypharmacy,"[3] namely, an emphasis upon alleviating pain with extensive drug therapy and, at the same time, satisfying the psychological and emotional needs of the patient who is to be viewed in the philosophy of "making ready" for death. The significant quality of this latter observation becomes the essence of the adjustment to St. Christopher's Hospice's philosophy. Are we ready to deal with death in a preparation which deals with a therapeutic settings of environment, versus the physical recuperative period which is non-existent? Clearly, our culture emphasizes a sense of optimism which makes ready only for accepted improvement, rather than the reassurance that death is a continum of life

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[3]Ibid., p. 142.

and is not to be feared. Admissions, on behalf of the patient, family and staff to this latter observation, becomes a total involvement in "make ready" for death.

The free interchange and participation in a positive way underscored a minimum of trauma and the transition becomes a reassurance of this continuum.

Saunders and St. Christopher's Hospice is more than a program of hospital care and comfort for the persons involved; it is a total program dealing with the dignity of life and the dignity of death. We pay a sense of token respect to this latter concern of dignity and we underscore the quality that the patient is very important. The largest question is, having made this statement, are we willing to deal in a dignified way in the process of transition? The hospice is a service which deals with life, death and bereavement and supplies the emotional needs in all phases of integration.

The poet was correct when he suggested that birth is a beginning and death a destination and that life is a going, a growing from stage to stage. Saunders and St. Christopher's Hospice deal meaningfully with this large philosophical question of how one can deal with the needs of the individual, not only in the last stages but, most clearly, in the constant stages of step by step.

A Place to Die

At present there are nearly thirty hospices in the

United Kingdom. Although they are not all called by this name, they nevertheless have much in common. They believe that the atmosphere which is so important for their patients and their staff stems largely from their independant status, and in many cases, their religious foundation. Most of them give the majority of their beds to patients with terminal malignant disease. Some, like St. Christopher's, also admit a smaller number of people with other diagnoses but with one factor in common, they are patients who need longer term and more personal nursing and medical care than can easily be given in a busy general hospital. St. Christopher's also has a wing of sixteen bed-sitting rooms for elderly residents, the long stay patients, the Outpatient and Domiciliary Service and the small number who are discharged after unexpected improvement (some 10% a year), all counteract the tendency of those outside to give it the alarming title of a "Home for the Dying."[4]

How the Hospice Differs from the Hospital

Hospices grew up along the pilgrim routes of the Middle Ages as places of rest for travellers. The word continued to be used and was extended to hospices for the elderly, the incurable and for foundlings. In the 19th Century it began to mean a religious foundation with a special care for the dying. St. Christopher's returned to the

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[4]Ibid., pp. 91-94.

early beginnings and has emphasized that its community is part of life and the Hospice a place for the living, the young and active as well as those who are passing through the last stages of their lives. The atmosphere owes much to its residents; the elderly in their wing as well as the many visiting students and graduates.[5] Perhaps its unique atmosphere owes most of all to the children of the Playgroup. Their mothers are members of the staff and bring them to lunch with everyone in the general dining room. Patients may meet children in the grounds when they out in beds and wheelchairs to the garden, which also has room for a sandtray, the paddling pool and a stock of cycles and toys.

The aforementioned presents in capsule form some of the basic theory as explained by Saunders for those who wish to understand the philosophical principle on which the hospice was founded. The following represents my personal reactions to St. Christopher's Hospice which I visited in January of 1976.

It was January 17, 1976, 7:00 a.m. when I left Victoria Station, London, for Pendge East, on a rainy day. As I arrived in the town station, I started to ask questions concerning directions to the hospice. This was the very day that the London newspapers carried the vote of Parliament which failed to substantiate the right of incurable patients to have their lives terminated. As I passed through the

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[5]Ibid., p. 43.

village of Pendge East, I stopped and asked a shopkeeper directions to St. Christopher's Hospice. His response was a question, "Do you mean the old folks' hospital?" With a hesitancy, I responded "yes," but a strange feeling ran through me, namely, was death only arranged for the aged and don't young people die? Nonetheless, with this question unanswered concerning youth and aged people, I proceeded to the hospice.

We live in a society whose assumptions set our pattern of thinking and though we all recognize that the young person can be terminally ill, we, nonetheless, have relegated such illness to aged persons.

The hospice was a busy place. I was received by the Medical Director, Dr. Cecily Saunders, who warmly and sensitively let me understand that the role of the hospice was to deal with the living, and that death was a termination point. Quite conscious of the obvious questions of pain, adjustment and concerns, Dr. Saunders let me understand that this was not a "Death Center" but, rather, a program of the extended family which met a need which would be better served, when possible, in the home through the domiciliary service. She then elaborated on the purpose of the hospice, to fulfill a need which is otherwise difficult to serve. Quite clearly, a woman who was initially a social worker and re-identified her career to better serve people in this aforementioned need, she pursued medical studies. Dr. Saunders tried to remold a society which was

not dealing with the psychological attitudes, realities and fantasies that often overcome us. The philosophy of St. Christopher's Hospice and the application of this philosophy in a very real way, identified itself with the word need, hyphenated with the word humanizing. "People who are needed by people are the luckiest people in the world," becomes the philosophical foundation for those who work within the hospice, be they the nursing staff, the custodial staff, the social work staff, or the medical staff; a philosophy which draws upon technical resources which emphasize human communication.

In the pamphlet which is distributed by St. Christopher's Hospice in its annual report, is the basic philosophical concept describing the patient-family relationship saying, "Practical efficiency combined with love for the individual."[6] Here we see the term need and humanizing merge together into an effective process. The center of family life are people and, therefore, the individual needs are fulfilled. This identification with personal desires and a recognition of individuality, makes it possible for St. Christopher's Hospice to deal with its unique organization and agenda.

The use of volunteers, approximately 120, and the presence of children who are related to both staff and

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[6]Cicely Saunders, The Working of St. Christopher's; Medical Care of the Dying patient, foundation of Thanatology, for private circulation only, 1975.

patients, makes the setting of the hospice "homelike." It is interesting that the "Draper's Wing," of sixteen bed-sitting rooms for elderly residents, adds a tone of senior citizenship for those who are related to staff or patients who reside at the hospice.[7]

The purpose of this report is to underscore a value system which addresses itself to need, and the sensitivity to the patients and the family all become part of that need.

Saunders quotes the words of Richard Cabot, a terminally ill patient, on the need for such a program, when he said, "I will be a window in your home."[8] This inscription on the large window in the reception room sets the tone of the attitude for the visitor, as well as for the person who engages in the work of St. Christopher's Hospice. Words like, "contentment," "reality," " beauty," and "communication," are essential to this program.

I quote from the words of Maimonides, "Let me see in the sufferer the man alone."[9] The care of the patient, with all the help to let him live as normally as possible and to give him a home or institution suited to his individuality and dignity, is the direction which St. Christopher's Hospice takes. With unhurried attention, the need

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[7]Ibid., p. 17.

[8]Saunders, Care of the Dying, p. 4.

[9]Moses ben Maimon, Guide to the Perplexed (New York: O.M. Pub., 1946), p. 96.

of the patient is filled. The filling of his boredom and apathy with meaningfulness and a sense of life, makes the work of St. Christopher's Hospice a very important experience, well needed for our society. The key words of St. Christopher's Hospice are the words, "Needs and humanizing."[10] (And if, we would attempt to relate how one can best create an atmosphere, a setting, an environment of dying, these words must be the keynote.)

If one reviews the literature, we find that such basic themes as "How the Living Feel about the Dying" and "Moral Implications in Counseling the Dying" and "Philosophical Consideration in Counseling the Dying" and "Religious Considerations in Counseling the Seriously Ill or Dying Patient,"[11] are but a few samples of some of the sensitive questions which are explored. The hospice is a very humane and sensitive way of confronting death and the related feelings. Understanding human grief in coping with both treatments and personal feelings, are well dealt with in the hospice program.

Quite simply the needs of the dying patient are:

1. Relief from distressing symptoms, pain and the fear of pain.
2. An environment of caring where his demands can be met without his suffering the fear of being a burden.

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[10]Saunders, Care of the Dying, pp. 18-28.

[11]Barney G. Glasser and Anselm L. Strauss, Time for Dying (Chicago: Aldine, 1968), pp. 14-31

An environment where his individuality and integrity as a person can be maintained.

3. Time and opportunity to voice his fears, to come to terms with himself and his illness, to draw close to his family.

Doctor, nurse, minister, psychiatrist, occupational therapist, as well as entertainment and beauty care, are all part of a patient's needs.[12]

Generally speaking doctors and nurses see themselves in curative roles. In the average general ward more patients go home than die. Death is therefore looked upon as a failure to cure. The dying patient is, in a sense, an embarrassment. Where there is staff shortage, it is the patient with a good chance of recovery who will absorb much of the staff's attention. A dying patient will sometimes apologize for being such a trouble, feeling guilty perhaps for taking time from others. He is the exception and his uniqueness isolates him. For convenience, the dying patient may be moved to a corner or a side ward and is thereby isolated even more. The breathless speed of a busy ward is ill-suited to the dying patient's need for tranquility and peace.

B. THE HOME (ADVANTAGES OF DYING AT HOME)

The home seems to be the natural place in which to die, with familiar things and familiar faces around one. Many a patient longs to go home and many a family would

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[12]Margaretta K. Bowers, Counseling the Dying (New York: Aronson, 1975), pp. 18-28.

would gladly have him home, but anyone who has tried to care for a dying relative at home will know the problems.

The literature which is available on the subject of attitudes, care, and the process of translating a meaningful program for the twentieth century, and clearly into the future, is best exemplified in the kind of work that one sees transpiring daily at St. Christopher's Hospice.

All of the above only offers in broad strokes, the working of St. Christopher's Hospice and the philosophy of its medical director. The needs and achievements of the program and the individual patient are crystal clear to observe and, yet, difficult to describe. The following represents a single story of how the hospice helped a dying patient and his wife to live together until his death and how it continues to help her to maintain a meaningful life.[13]

The patient, a 72 year old, retired sales representative of an engineering firm, had retired at the age of 64 after suffering a coronary. At the time of his admission to St. Christophers he was alert, intelligent, self-disciplined, and appeared to be a well-organized individual. He was referred to St. Christopher's following his discharge from a regular hospital where he had undergone surgery for an inoperable carcinoma of the esophogus. He had had a celestine tube inserted in the esophogus, but had been given only a short time to live. His wife had been apprised of

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[13]Saunders, The Working of St. Christopher's, p. 1.

the seriousness of his condition, but at first had refused to accept the verdict, and put her hopes into "a miracle."

The patient and his wife appeared to have a close relationship. After his discharge from the hospital, she was more than willing to assume the burden of care that he required, but was concerned that he might become ill while at home. She wanted to keep the prognosis from her husband and the doctor concurred.

At first, he was seen at home by a nurse from St. Christopher's but finally the treating hospital asked that his care be taken over completely by St. Christopher's. For the next nine months he was seen as an out-patient at the hospice.

As time passed, he started to suspect the worst and had long conversations with the out-patient doctor. The doctor finally decided that he was ready, and told him of the prognosis. His wife was relieved to have it in the open and relieved that they could now be open with each other. She was tearful, but resigned and composed.

A month or so after having learned of his impending death, the patient wrote: "The problem is posed: when should a patient be told that he is suffering from an incurable illness? In general terms this is unanswerable, thus it is necessary to draw on one's own experience, and this I will endeavor to do." He went on to say that he had always had a subconscious dread of surgery. He was very apprehensive when he went to keep his appointment with the surgeon

for the first consultation. But the surgeon was very open and forthright and the patient's fears were allayed by his honesty. He felt confidence in the surgeon and felt he was safe in his hands.

Following the exploratory, he was told that he had a tumor of the esophogus and would require major surgery. As before, since it was all spelled out for him, he was given all the details, he was able to accept with equanimity the prospect of major surgery.

Following the surgery and the usual post-operative discomforts, he found that he still had difficulty in swallowing and became quite depressed. Eventually though, he was able to manage small quantities of soft foods, and by the time of his discharge from the hospital, his confidence had returned.

On first being discharged, he felt that he was making remarkable strides toward recovery and started to plan future activities in which he wished to re-engage. But, his strength started to fail again and depression set in.

The Sisters from St. Christopher's started to visit him at home and he was invited to attend the Clinic. He soon started to anticipate his visits to the clinic with pleasure and as the treatment started to bring some form of improvement, his depression lifted and he started again to feel new interest in life and his surroundings.

It was about this time that the "germ of suspicion" that there might be more wrong with him started to germinate and fester in his mind. He made some probing observations in the family to see if they were keeping anything from him, but learned nothing. His suspicion crystallized and he determined to ask the doctor outright. The doctor apparently had come to the conclusion that the time was right and the patient was ready to be told the truth about his condition.

Rather than feeling fear or shock the patient found that having his worst fears stated and crystallized in an honest manner brought relief from the doubts that had been plaguing him, and these doubts were now replaced with a feeling of calmness and acceptance; and so, to use his words, "I was able to analyze the situation." It was the patient's own analysis of the situation that made him realize that he could not have coped with that knowledge immediately following the surgery or in the ensuing months when he faced the weakness and depression. So, the timing was of the essence. The patient himself concurred with the judgment that he could not have handled the knowledge earlier that there was no cure for him. He recognized that each individual patient must be treated according to his own personality and needs, and the doctor through his frequent contacts with the patient is best able to judge the timing element.

The patient's wife also wrote out her feelings and

reactions. She stated that on being told by the surgeon that her husband had been through a severe trial and had only a short time to live, she went into a severe shock, "my whole body seemed to freeze and I seemed incapable of understanding fully what this meant." This state of shock lasted a week or two, and then she slowly started to recover her equilibrium. She had, on being informed of her husband's condition, requested that he not be told since she felt he was too weak to withstand further shock.

Immediately following her husband's discharge from the hospital, she determined that, as much as was humanly possible, life should go on as before. She had come to grips with herself. She determined that she would do everything in her power to help restore his health. As his condition seemed to improve, and he put on some weight, her spirits rose. The time given by the doctor, a couple of months at best, passed , and he continued to improve, "hope springs eternal," and she started to believe in a repreive, perhaps for as long as a year or two.

But slowly, the patient started to lose weight again and had begun visits to the clinic and to receive home care from the Sisters. The clinic proved to be such a tonic for him, that when he began to hint at his suspicions, she felt that, with the help of the Clinic, he could now handle the truth. She was right. He took the news very well, as she knew he would, and she was confirmed in her decision that it was right to wait until he had regained his composure

before the truth was revealed to him. They shared the experience and were able to discuss the future without difficulty and to make whatever arrangements were necessary accordingly.

All of this is not to imply that these months were free of difficulty. He had problems with the tube blocking, which were released through simple measures such as fizzy drinks, and when pain began, it was controlled with small oral doses of a narcotic analgesic given regularly.

He had been most anxious to have Christmas at home, and with the cooperative efforts of the Hospice nurses, who visited him at home and supplemented the visits of the District Nurses, this was achieved. By this time he required regular injections, and the nurses saw to it that he got them at home. He was admitted as an in-patient at St. Christopher's after Christmas.

During the time he was in the hospital he kept his spirits up. He welcomed all who came to see him and participated in the teaching rounds in the wards. In addition he organized a concert of his favorite records for the other patients. He died quietly two months later. During the final two months in the hospital, he maintained great control and dignity.

In these last weeks before his death, he had many conversations with the chaplain. In one tape recording made with the chaplain, the patient explored his attitudes toward God and organized religion. He expressed feelings that,

though he had in the last few years, withdrawn from religious beliefs and views, had questioned established Christian-values, because "somehow the world seems to be in such a turmoil....it doesn't seem possible that there can be anyone in charge." He felt as though everything were out of control. But as his illness progressed, he felt a need to say "thank you" when he felt better, or the anticipated pain didn't come, or when his outlook was better. "I felt that here I am accepting these gifts and not saying "thank you," and I think I have come back into the fold in some measure." He felt that there were still many unanswered questions in his mind, and he needed answers to understand and accept, but nevertheless, there was no doubt in his mind that there was a Power, or a Being, or something in control. He no longer had the feeling that mankind was rushing toward its own destruction "without anyone watching over us." He still could not accept church ritual, and felt that to go into the woods and say a prayer is as potent as going to a cathedral.

The patient's wife throughout all of this maintained her calm and her dignity. She lost control one day while sitting at his bedside. Thinking that he was asleep, she let the release of tears come. He awoke, and he was the one to comfort her.

After only a few days of increasing weakness, he died peacefully in his sleep. With the exception of only one short period of confusion, he never lost his awareness

of what was going on around him, nor his control over it. The final summary:

> Seemed fairly cheerful but became very breathless on exertion. Took a small light diet. Occasional nausea and vomiting. Looked very frail by mid-January but continued to be uncomplaining and brave. Condition slowly deteriorated and patient had bouts of acute abdominal pain during the second week in February. Complained of double vision on 23/2. Vomited coffee grounds material and looked very ill. Condition continued to worsen, but patient got out of bed and sat in a chair on 26/2. Deteriorated further and died peacefully on 27/2.[14]

This is the story of support for a patient and his family - but, more important than that - it is the story of the life which Mr. and Mrs. P. led together while he was dying and of the achievements they made.

This case study presents but one of the thousands that St. Christopher's Hospice has been able to deal with, with dignity, and humanness. Its philosophy is one which translates every twenty-four hours the possibility of a contract between the health services and the patient, the true bridge of relationship. The ideals and aims of St. Christopher's is summed up by the words and experiences of Dr. Cicely Saunders. Not only skill but compassion, also, is the key to St. Christopher's Hospice.

> We want to plan and carry out research in the relief of distress such as has not been done anywhere else, so far as I have been able to discover. It is often easier in a specialist setting to go on learning in this way and by building what we think is an ideal unit we hope to be able to help not only our patients but to raise standards generally and also to stimulate

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[14] Ibid., pp. 2-6.

> others to think about these problems. A patient comes to my mind here, a young woman who said 'You seemed to understand the pain from both sides.' Our aim in learning such understanding is to give the kind of relief described by another woman who said 'It was all pain, but now it's gone and I am free.[15]
>
> Seventeen years ago a young Pole died and left me 500 pounds to be 'a window in your Home.' This was the very beginning of St. Christopher's. I also remember his saying, 'I only want what is in your mind and in your heart.'[16] This was echoed years later by another Pole-who said to us 'Thank you. And not just for your pills but for your heart.' I think both of them showed that they wanted not only skill but compassion also. They needed warmth and friendship as well as good technical care. I think our understanding of what real watching means must include this. We have indeed to learn what this pain is like. Still more, we have to learn what it feels like to be so ill, to be leaving life and its activity, to know that your faculties are failing, that you are parting from loves and responsibilities. We have to learn how to feel 'with' patients without feeling 'like' them if we are to give the kind of listening and steady support that they need to find their own way through.[17]
>
> Here again comes a key phrase I have often quoted - 'I look for someone to look as if they are trying to understand me. These patients are not looking for pity and indulgence but that we should look at them with respect and an expectation of courage, a heritage from seeing people like the woman who said to me 'You can tell them all that it was all right.' She was not going through a strange, dramatic or just unlucky experience, to be written up as such with sentimentality or sensationalism, but an all-too-common experience such as ordinary people have always faced and somehow manged to come through.[18]

The admission procedure, staff, treatment of pain are all presented in a very special way at St. Christopher's Hospice. The staff in the admissions office consider that it is their responsibility to listen to and advise the

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[15] Saunders, Care of the Dying, p. 47.

[16] Ibid., p. 4. [17] Ibid., p. 13. [18] Ibid., p. 24.

enquirers and are often able to make suggestions about other hospitals or organizations which can help them. Often it is clear that the chance to talk on the telephone was all that was needed to enable the enquirers to sort out their problems. Between 500 and 600 of the remaining patients will be admitted in a year, about one third of them direct from other hospitals. Like Mr., P., most of those who come from their own homes will have been visited from the Hospice. On the average, some three months elapses after a first enquiry before admission is needed, and each year 40-50 patients are able to stay at home until they die. Once they know that the Hospice will help if needed, some families manage without any further help. One of the local doctors has repeatedly said that he puts patients on the list as a form of insurance because he has found that this so often means that admission will not, after all, be necessary. It is extremely rare that any patient in distress at home fails to be admitted, although there may not always be room for a patient referred by another hospital from their beds.

The number of people St. Christopher's has been able to help is increasing. During the first full year (1968) 380 patients were admitted, during 1972 the number had risen to 490. The median length of stay has ranged between 18 and 13 days.[19]

The relationship of staff and their involvement is

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[19]Saunders, The Working of St. Christopher's, p. 7.

an important part of the concept. The nurse/patient ratio is the same as that in an acute ward, that is the equivalent of 1.25 whole time nurses for one patient bed. About half of these nurses are trained and the rest may have had little or no experience when they first arrived. The Hospice carries out its own in-service program for them and finds that they, like the many volunteers who are involved in nursing duties, have a valuable contribution to make. Half the nursing staff are whole time and work under the same conditions as nurses in the National Health Service with somewhat generous arrangements for special leave. The rest give the amount of part-time work they can manage and their fair share of evening and week-end work whenever possible.[20]

The doctor-patient ratio is also fairly generous but most of them are involved in administrative and teaching responsibilities, as well as in patient care. Every effort is made to enable each patient to talk alone with a doctor several times in the week and at any time a crisis arises. The doctors are also constantly available to the nurses, who take a considerable amount of responsibility in making decisions both in the wards and in the patient's home.[21]

The treatment procedure takes a unique approach. Symptomatic treatment is mandatory and calls for the modern equivalent of the elegant prescription of a former generation of physicians. There are many ways of helping dyspnoes,

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[20]Ibid., p. 17. [21]Ibid., p. 23.

anorexia and nausea, bowel disturbances, incontinence and all the other common trials of terminal illness. This constant giving of attention to detail and the discussions between all members of staff which this involves, develops a positive attitude among them, and in turn this is transmitted to the patients. The diagnosis of terminal cancer is not in itself a reason for using powerful analgesics, although it should certainly modify one's attitude to their use. Weaker drugs are often adequate, especially if pain is treated specifically wherever possible. We believe that analgesics should now be used to prevent pain from occurring rather than to control it once it appears, exacerbated by anxiety and tension. The analgesics are written on the drug chart along with other routine medications, and the nurse is expected to give them on each round. The dose is balanced to the patient's need so that the pain is controlled adequately for a period slightly longer than the elected routine time. The time schedule is not rigid to the minute, and we find that this prevents clock-watching.

No one wants to die, but if, indeed, we are to address ourselves to the emotional needs of the dying person, relatives and friends, then St. Christopher's Hospice and the work of Saunders has brought the concept to a meaningful process.

Two recent comments sum up the aims of teaching in the Hospice. The first from a doctor who was a resident

visitor. "The patient in the bed is a person and is my equal - that I happen to be the one who is helping him is really immaterial." The second is from a student after an afternoon teaching round. "I think I have gained a small insight into the use of both drugs and of oneself to help the dying patient, and the whole patient rather than just the diseased body."[22]

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[22]Ibid., p. 29

CHAPTER V

CARING FOR THE DYING

The keys to a culture are in its words. Consider the terms for death and see what they say about the world views of the communities from which they come. The biblical term is "to be gathered to your ancesors," which means to become a part of history. It is a way of stressing the community dimension of our human existence. The classic Jewish term for death is NIFTAR, which means "to be released from service." The conception is that this is the world of work, of commandments, of accomplishments, of opportunities to do things for God. That is the world of rest, of return, to which one is summoned when one has accomplished his task. The modern word is "passed away" - a pale, vague, wishy-washy word which does not say much or mean much because we are vague and unclear ourselves in how we feel about death. The central religious truth is that life is a loan and death a return, that after intelligence there must come trust, that after acquiring there must come surrender, and that after having there must come being.

The religious laws are meant as ways of serving God; their by-product is that they bring healing and health to the bereaved. They are immensely technical, even sometimes petty, but they prevent excess and they prevent

excess and they prevent sloughing off a loss as though nothing had happened. To say that death is not significant enough to mark in special ways is to say that life is cheap. Many of those who do not have the time to work out their grief in the time of loss end up spending much more time on the psychiatrist's couch working it out later.

Those who counsel the dying patient must examine some of the moral and ethical questions involved in this counseling process. The patient's spiritual and psychological well-being is indeed a responsibility, inviting consideration of the following questions. How can we know what is the truth? How do we gauge the patient's tolerance for the truth? How much truth is the patient entitled to know? How much of the truth can legitimately be withheld from the patient? How is the truth involved in the diagnosis, prognosis, and therapy of the patient?[1]

Among the most difficult arts to speak of and teach is that which relates to attending to the needs of others. Who among us has ever felt adequate when called upon to bring words of consolation and strength in the tragic moments which fill the lives of people. The years do not season our wisdom but only emphasize a certain sense of inadequacy that we are deprived of understanding, as well as technical ability on how to meet this need.

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[1]Margaretta K. Bowers, Counseling the Dying (New York: Aronson, 1975), p. 97.

Communication

Out of the extensive experiences with terminally ill patients, Elisabeth Kübler-Ross has detailed how the terminally ill react to their illness. Quite clearly, it is not the task of the ministering person to move the patient from one stage to another, but it is the task to be available when called upon to assist in this journey. Edwin Shneidman, Elisabeth Kübler-Ross, and Cicely Saunders appear to differ on the stages but not the process by which the dying person moves closer to death.

The communication we speak of with the dying patient is hazardous, because it calls for a journey into no-man's land where one cannot long claim omnipotence. There is an empty space, where the ultimate communion between man and God, creature and creator takes place. While it is a product of consciousness, it always implies more than mere consciousness. As lungs mave no meaning without air, and eyes no meaning without light, so the capacity for God-consciousness raises the questions of ultimates, unknowns that cannot be treated lightly. We would all like to gain power over death by knowledge, by scientific achievement, by philosophic sublety, but in truth all these efforts fall short when the unknown wind blows, and none can tell whence it comes and whither it goes. We would like to capture the secret of life and the dying person often appears to be on the verge of capturing that secret.

Sometimes we are afraid of the knowledge he may gain, and deny it can exist for him, and at other times we hide our face, as if fearful to look into the too brilliant light. The clergyman can embark with the patient on a mutual search for some kind of meaning. For the clergyman and the physician who honestly enter the quest, not with false claims of an impossible omnipotence but with the companionship of honest sharing, the very silence becomes rich in communication, for then they are sitting quietly together rather than quietly apart.

Search for Meaning

Man's ultimate challenge is in his death, whether it has meaning or whether it is the final triumph of meaninglessness. In pain, a person can endure much more if it has meaning to him. A prisoner in a German concentration camp said he was able to endure the beatings and the torture to which he could attribute some meaning, but when they stripped him, cut the buttons from his short, and sewed them on his skin, he collapsed with the pain, for the act was so completely meaningless. The quest for meaning gives to pain and death a direction and purpose

Ministering to the Dying

Most probably, the greatest failure or frustration which wells up within the ministering arts is a true understudy of the inner process within the dying patient. Herein

lies the mystery of how to minster to the dying person. If we see death as a last gift that will withdraw the pain and uncertainty for the dying patient, then the bridge-building has one quality. If the mystery is thickened and the quality of comfort is diminished, both physically and psychologically, then the complication is emphasized because of the forces which affect multi-directions.

It has been correctly observed that for those who have a strong religious commitment, the process is more definitive and the direction easier to understand -- for it brings us from stage to stage.

Conflict

The burden of self-consciousness which rests so heavily upon man is the root of his inner conflict. He can objectify his behavior and its meaning. He can accumulate meanings, which becomes history. He can pass on meanings, which becomes education. In his self-consciousness he craves a freedom he cannot have, because he is continually engaged in limiting it by his history and education. So his conflict is a built-in hazard and resource because through it he struggles to gain freedom through control, and the control becomes the soil from which science, the arts, philosophy, and religion emerge.[2]

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[2]Ibid., p. 119.

Psychic determination

Some have suggested the possibility that future scientific endeavors might prove the principle of psychic determination in death and, consequently, format an agenda. The language that this implies is not only psychological and philosophical but, also, deals with a theological implication, namely what role does man play in determining his own possibility for physical life.

Cultural Role of the Clergy

I am certain that the counseling minister is alerted to his strengths in the area of encouragement, the larger question rests with his strengths in the area of discouragement. It is, therefore, significant that we address ourselves to this latter concern since it significantly dovetails with the ministery to the dying person. Probably the most difficult area that one deals with in this regard is whether it is to the advantage of the dying person, as well as the "Other persons," that we position ourselves as a helping hand to bring about a finality in a quicker way. Our culture has emphasized this role, so much so that the very visitation of the ministering individual is connotated with a negativism and, thereby, removes the optimism which formerly might have existed. The very colors that we have attributed to death and those who are within the ministering arts, are synonymous colors. It is indeed, important for us to see this in light of the

earlier observation, namely, what role is played by the minister to the dying person.

Dr. James Nickson, Director of radiological research at the Memorial Hospital in New York, says:

> Life, like a diamond has many facets. Medical science with its researches and its limitations can throw a certain type of light on life. But there are many other facets with their types of light. They must all be brought together to add to our understanding of man and his health."[3]

Allegory, Symbolism, Language & Social Taboos

Allegory and other instruments of story telling attempt to bridge build between the earthly pilgrimage and the mystery of death. From early childhood on, within our value system, we tend to minimize that which is self-maximized, namely that there is something which rests between our earthly pilgrimage and the unknown. The possibility always clouds the clarity.

Symbolic language and the inability to approach this untouchable subject, becomes supported by the non-verbal communication and the symbolism which grows out of our lack of physical touch or caress to the dying person. The ministering person is perplexed, not by what one does but, rather, by what one does not do and, herein, rests the complication for the family as well. If, indeed, the number of visits which the physician makes become diminished and the availability of the other members of the healing

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[3]Ibid., p. 151.

arts staff become noticeably less attentive, this then becomes even further complicated by the clergy-person who is entellectually and emotionally handicapped as to which direction the bridge is to be built.

We have taught honesty and trust to the patient. It then becomes a problem when we are unable to assist the terminally ill patient with the same honesty at this crucial moment. Then the role of the minister is now clear, and calls for consistency of honesty. I had offered in the statement of the problem, the words that Tolstoy had emphasized in "The Death of Ivan Ilyitch" when he made the following observation, "What tormented Ivan Ilyitch most was the deception, their not wishing to admit what they all knew and what he knew but wanting to lie to him and forcing him to participate in that lie...and he had thus to live all alone on the brink of an abyss with no one who understood or pitied him."[4]

The key word, amongst other definite thoughts that one lifts out, is the word pity. If, indeed, dealing in a ministering fashion with the dying patient comes down to pity, then the patient is placed into a defense of personal pride, or what we often refer to as self-respect. It is here that we have a withdrawal which then sets an atmosphere impossible to minister within, for the wall that separates

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[4]Leo N. Tolstoi, The Death of Ivan Ilyitch (New York Charles Scribners Son's, 1904).

becomes taller and the comfort of sympathy becomes less significant.

Problem and Tone Setting or Effectiveness

If this project has underscored the problem and lifted up the possibilities, then ministering to the dying person can, indeed, be supportive if it deals with the possibility of strengthening a relationship with the totality of life.

An additional thought speaks directly to this pattern of problem and tone setting, namely, we are only as effective in dealing with others as we are in dealing with ourselves. The minstering person must be self-convinced and properly prepared to meet the need of another, having met his own needs.

The pastor who can find this relationship with the dying patient is free to identify with the person and his experience in understanding, if not in fact. At this point he engages in a supreme form of communication. But he can only do it if he is secure in the faith that grounds his being.[5]

Ceremonies and Rites of Passage

There seems to enter into our ceremonial pattern and

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[5]Charles C. Bachman, Ministering to the Grief Suffered (Philadelphia: Fortress Press, 1964), pp. 121-127.

the rites of passage, the ethical duty of what one attempts to do, in a meaningful way, for the family after the death of a member of that family. Each society sets up its own patterns of ceremonies and each attempts to deal with the unknown emotions which dwell within the inner part of the individual. It is not unusual to see a very specific spot set aside for seclusion or withdrawal and a formal re-entry into society when the grieving person has completed his own journey through the valley shadows.

Dynamics of Grief

The consequences of the absence of forms of mourning is that the grief stricken is offered no acceptable way of expressing his sorrow, and instead, he must turn his feelings inward. For this reason, many persons tend to leave the bereaved alone and enforce a sense of isolation and loneliness that is already present. It is, with this in mind that we turn to the role of the minstering arts to explore the dynamics of grief. Jack D. Spiro, in his volume, "A Time to Mourn," underscores the dominance of anxiety in the dynamics of grief.[6] One distinguishes grief and mourning in that the former expresses sorrow, while the latter is a means by which a person attempts to handle the suffering and emotional distress which is caused by

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[6]Jack D. Spiro, A Time to Mourn (New York: Block, 1967), pp. 3-20.

bereavement.

In the area of anxiety to the grief response, we can well see the thoughts of David K. Switzer in his volume, The Dynamics of Grief,[7] when he points out:

1. Separation anxiety, threatening self-loss.
2. Guilt or moral anxiety.
3. Fear of one's own death.

Probably the most complicated part of anxiety is one's own ego defenses which finds expression in denial, repression, self-punishment, projection and other unacceptable and undesirable behavior patterns, including a sense of emptiness, which becomes even more accentuated by a sense of despair.

Colin Parkes[8] notes the factors that are determinants in the experience of grief and this list becomes extensive:

1. ANTECEDENT
   Childhood experiences (especially losses of significant persons)
   Later experiences (especially depressive illness)
   Life crisis prior to the bereavement
   Relationship with the deceased
   Kinship (spouse, child, parent, etc.). Strength of attachment
   Security of attachment
   Degree of reliance
   Intensity of ambivalence (love/hate)

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[7]David K. Switzer, The Dynamics of Grief (Nashville: Abingdon Press, 1970), p. 120.

[8]Colin Murray Parkes, Bereavement Studies of Grief in Adult Life (New York: International Universities Press, 1972), p. 27.

Mode of Death
- Timeliness
- Previous warnings
- Preparation for bereavement
- Need to hide feelings.

2. CONCURRENT
Sex
Age
Personality
- Grief proneness
- Inhibition of feelings

Socio-economic status (Social class)
Nationality
Religion (faith and rituals)
Cultural and familiar factors influencing expression of grief.

3. SUBSEQUENT
Social support or isolation
Secondary stresses
Emergent life opportunities (options open)[9]

Re-Emergence from Grief

The most crucial questions and issues which rise in our understanding when working through grief is the question of how to restore relationships. If, indeed the disturbing elements of unusual response become deep seated, then we are dealing with an irrevocable situation.

Some of the components which bring about the aforementioned are the preoccupation with minutiae, the painful recollection, and the attempt to make sense of the process.

The steps in the return to life are five. The steps may be of varying duration and in many instance may overlap: but at some point in the process, they are clearly

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[9]Ibid., pp. 29-40.

identifiable. The first two steps may be met in large part by many before the death occurs, if there is involved a lingering illness; this also takes the edge off the trauma of the third stage, but may leave the survivor to cope with a sense of uselessness, at least for a time. These are the steps:

1. "I don't believe it, God!" It is marked by rejection of the fact of death, as in accidental or sudden death occuring away from the immediate community. It is marked by confusion, incomplete sentences, and memory lapses. Usually, this condition is of comparatively short duration, unless fantasizing takes place.
2. "Why me, God?" A deep resentment is present, mixed with aching hurt, as if being cheated of something of life which is given to others to enjoy longer. This is usually rooted in the lack of acceptance as to their own termination, and the lack of appreciation for the unique and qualitative aspects of interpersonal relationships as encounter and communication. Anger may be the means of "striking back" because of hurt; and the funeral director, the visitor, the clergy, the doctor - all are vulnerable targets. If the grief process is arrested at this point, the person may become bitter with complex negative responses, and make it a habit to lash out at anyone in his normal social relationships. For

the average person, this period should be of short duration, from a few moments to a very few days.

3. "O My God!" This is the deep trauma period with psychosomatic overtones and its onset is usually from seven days to three weeks after the decease of the loved one. It lasts from two to five days in most instances. There is a tendency for this period to come a little later with those who have internalized their religion, but the trauma in such instances seems not to be so deep, or so long. I have known one case in which the trauma did not occur for almost four months. As a rule, the longer the period before onset, the more crucial its characteristics. This stage shows itself in most cases in one of three ways: (a) as sudden extreme general weakness, sometimes with fluttering sensation; (b) as onset of "flu" - vomiting, diarrhea, sweating, general weakness; or (c) as sudden aggravation of an already existing disorder, predominantly cardiac, rheumatoid, respiratory, glandular, or circulatory. This period may cause certain latent psychological problems to surface -- schizophrenia, paranoia, or hypochondria. Sometimes alcoholism and/or a dependence on drugs asserts itself. The latter may have been given to the grieving person by some well-meaning friend.
4. "Quo Vadis? What's the Use?" This period is

characterized by extreme uselessness; now is the time to resume activity -- to do something that you want to do! (The assertion of the self!) Before the "breakthrough," irritable remarks and behavior may surface. This is good - the struggle for self-hood - individuality on one's own merits. This stage cannot be forced early by well-meaning friends. The person himself must institute this behavior pattern when he is ready for it. Either self-assertion or hopelessness (withdrawal from ongoing life relationships) must surface -- it's up to the individual. Suggestion, encouragement, and concern, lovingly given during this time, are valuable. This period also varies with the person, and can be from a few days to a few months. I have noted, however, that the crisis time usually occurs quickly, and is not unlike a plane's breaking the sound barrier -- gathering the extra power, and they are through the barrier. A part-time job, or other creative activity, can be helpful through the next period.

5. "I'm beginning to see the light!" Some find a new freedom for themselves, unhampered by personal responsibility to others, which they value. The person begins to smile more readily, and responds to the reaching out of others. They begin to feel at ease in the company of others. They begin to feel at east in the company of others, even with

those of the opposite sex.

6. "Free--at last!" The person resumes his/her full role in social interrelationships, marked by the concretion of his/her own life-style. We need to allow for variations in individuals, the development of "hang-ups," or arrests in the process. There may be a sudden psychological attachment to another span of time, the "running away" from the situation, or the upthrust of self-pity and resultant introversion.

Role of the Clergy in the Re-emergence Process

How can one who is concerned with the ministering arts help the grieving? Probably the most successful approach is that of reassurance and at the same time, the kind of support which allows the person to re-establish a world of reality. Dr. Edgar Jackson lists five phases in grief work and suggests what helps most. This is reported to us by Austin Kutscher.[10]

Phase	Helping Response
I. Numbness, shock	Be there
II. Fantasy - reality (it can't be)	Be there
III. Feelings of desertion, rejection, anger, guilt.	Let feelings come out
IV. Flood of grief	Encouragement

[10]Austin H. Kutscher, Religion and Bereavement (New York: Columbia University Press. 1971), p. 3.

V. Carry on as before Support[11]

These phases of response basically indicate a quality of support and is this not, indeed, what is the true essence of any relationship?

In the volume, "The American Funeral," by LeRoy Bowman,[12] he clearly evidences that the reaction, which is emotionally overwrought, requires the aspect of ventilation and, this calls for the professional ability to support -- in this case, he demonstrates visibly the essence of this support. It is, therefore, quite clear that the minstering after death, is in a true way, not much different than the ministering to the dying person in that it requires the self-same ingredients which are part of the support system.

The experiences of good inter-personal relationships with people and situations are systematically strengthened by their relationship to "understanding." Summarized within this one word is the essence of a pattern of life which addresses itself to a methodology of dealing with people and situations. Ministering is, therefore, part of the process of communication between persons as they relate to the immediate problem, as well as the overview of that problem as seen within the context of ongoing human relationships.

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[11]Ibid., pp. 20-27.

[12]LeRoy Bowman, The American Funeral (Washington: Public Affairs Press, 1959), pp. 46-52.

Understanding the art of communication

All of the studies that have been mentioned and all of the present efforts to graph human emotions, speak to the same direction in the learning theory process, namely, that it is how we respond which sets the tone for future relationships. By way of offering an example of this, I would refer to the philosophy of the disciplines of psychology which affirm that it is not only what we say that determines possibility of future relationships. With this in mind, I underscore the value of ministering to the dying as well as ministering to the family of the dying, both before, during and after this even.

Role of religious belief

Although each of us possesses a religious faith that enriches life for us, and though we recognize values of the religious tradition, we are presenting our view, not because they are orthodox or unorthodox, but because we feel they are valid and worthy of careful consideration in the care and treatment of persons in catastrophic conditions.[13] Seriously ill and terminal patients often are overwhelmed with loneliness and fear and turn to religion to break their isolation. Sometimes, in desperation, they turn to magical thinking. Sometimes, in the awareness of the approach of

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[13]John A. T. Robinson, IN the End God (New York: Harper and Row, 1968), p. 84.

death, they seek solace and dealing with unfinished business of life, so they turn their attention toward the acts of preparation.

Role of the Clergy

Clergy can serve a useful purpose with the patient, but this does not come by playing upon feelings of guilt - existential, neurotic, or real - with the expectation of bringing the emotional response that comes with fear and anxiety. Rather they can help mediate a healing, redeeming acceptance that enriches life, and moves the patient onward, a resolution of inner conflict. To fill the patient with morbid modes of thinking is not only cruel and out of keeping with religion, but it may also be physically and psychologically injurious to the patient, so that it may hasten his death. The clergy, often without being aware of what is happening, may be projecting their fear of death and their own anxiety.

On the healing team the clergy has a valid place in helping to release the patient from the burden of guilt and the stress of anxiety. He can help the process of true self-discovery and self-actualization. If there is ever a need for "the courage to be" it is at the moment when the prospect of non-being is encountered. The achievement of religious selfhood is not so much a matter of reason as it is of feeling, but wise guidance and counsel can help to achieve it. "The meaning of divinity is approached not

through the existence of things, but through the being of the Person, the Self."[14] This self-discovery that is beyond such phenomena as death should be the goal of the clergy-person with the patient who seeks in religion the help he needs in his personal crisis.

Too often the clergy retreat from a genuine encounter with the patient through verbal escapes and ritualized expressions that do not meet the need of the person who is trying to find the depth dimension. This may be just the beginning of the important growth that is possible. The clergy may share an awareness of the potential that may become actual at the moment of illumination when the person is aware of himself and is able to say "I am."

The fact that he existed and knew it, was loved and knew it, made many of the considerations so bound up with time and space irrelevant. The full knowledge of his being, his relationship with all that is, was already an experience of the eternal, because it did not depend on time measurements or location. To help the patient come to the end of his alloted time with the feeling that something in his being is timeless is great assurance. This may be what Paul Tillich speaks of as "the ground of being."

The clergy who can find this relationship with the dying patient is free to identify with the person and his

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[14]Paul Tillich, The Courage To Be (New Haven: Yale University Press, 1952), p. 78.

experience in understanding. At this point he engages in an important form of communication. But he can only do it if he is secure in his faith.

Science/religion: The relationship

There was a time when, according to Jung,[15] his patients wanted nothing to do with the clergy even though their basic need was for a religious orientation in life. He claimed that his patients described the clergy as inclined toward preaching, judgmental, easily shocked, and so rigid in his attitude that they knew in advance what he would say.

Medicine, which has regarded itself as a science; is now confronted with the basic problems of man's total nature. It must also become a philosophy with religious awareness. Unless it probes human motivation, it cannot deal with the roots of disease.

In his book, The Doctor and the Soul, Viktor Frankl presents a basic concern. As a psychiatrist he admits this his function is confounded unless he can create a meaning for life that has enough significance to stimulate the response of the patient. To this end, he speaks of a "medical ministry" not set up to compete with religion, but rather to face the moral and spiritual aspects of life that are an inseparable part of psychotherapy. Frankl contends

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[15]Carl C. Jung, Modern Man in Search of a Soul (New York: Harcourt Brace, 1933), p. 4.

that breakdown in function is bound up with a breakdown in meaning. Life falls apart when it fails to accept its major responsibilities, and in facing these facts medicine is compelled to move into the realm of values.

Psychological insight leads to a concept of man that demands answers to the important spiritual questions about life. Unless these answers are found, man will see no good reason for acting upon his insight. The religious approach is not concerned primarily with the treatment of symptoms but with the achievement of spiritual unity which produces wholeness of being. The insight that can be shed upon man's total health from an understanding of his spiritual nature and its processes is tremendous.

Spiritual Realization

It may well be that one of our tasks is to develop the idea that men can die healthy. While the physical equipment may wear out or break down, the achievement of the full measure of self-awareness and spiritual realization makes this terminal moment not a time of defeat but a final expression of faith.

This view of wholeness then could become one of the qualities of being that reveals the commitment of man to the destiny that is an innate aspect of his being. Faith then is not so much something you believe, as something you are.

For the person whose life has been a constant growth

in faith, love, and human experience, deaths hold no terror. God has always been with him and he knows God will always be with him. The less fortunate individual needs the clergy assistance more than ever before. If he has not the security of his own faith he needs someone to hold his hand, so that he can sustain himself through the final anxiety of separation by feeding on the faith of others. He needs to share his fears with someone whose faith can comfort and sustain him.

Where the individual has found a full measure of faith in himself and in the universe that sustains his life, he will find the meaning for his own existence so adequate that he will fear neither life nor death. When the clergy find for themselves and communicate to others this faith, they will see their work with the terminally ill and the dying as an opportunity to test their own faith as it grows in the ever-challenging process being and becoming.

APPENDIX

RITUALS AND CEREMONIES, PRINCIPLES, LAWS AND CUSTOMS OF MOURNING FOR THE JEW

LIST OF TOPICS

PRINCIPAL LAWS AND CUSTOMS OF MOURNING

The Ovel. One becomes an ovel (mourner) upon the death of a parent, husband, wife, child, brother or sister, including half-brother or half-sister.

The laws of mourning with the exception of K'reeah are not obligatory for children under thirteen years of age, and they do not apply when the deceased is an infant thirty days of less.

K'reeah. The rite of K'reeah, the rending of the mourner's garment, takes place at the funeral. The mourner stands for the K'reeah. For a parent, the rent is made on the left side nearest the heart. For all other relatives mentioned above the rent is made on the right side; for an infant thirty days or less, there is no K'reeah.

When a death occurs on a Festival or a funeral takes place on the second day of the Festival, the K'reeah is performed immediately after the entire Festival is concluded. But when a funeral takes place on Hol Hamoed (the intermediate days of Pesah and Sukkot) the K'reeah is performed on Hol Hamoed. If the mourner receives the news of the death and burial of a relative after the lapse of thirty days, there is no K'reeah except in the case of a parent when K'reeah must be performed regardless of how long a time has elapsed.

The blessing recited for K'reeah is: Bo-ruh a-toh

a-do-noy e-lo-haw-nu me-leh ho-o-lom da-yan ho-e-mes. "Blessed art Thou, O Lord our God, King of the universe, the righteous Judge." This blessing expresses resignation to the judgment of God.

Shivah (Seven day period of mourning). Shivah begins immediately after the funeral. The day of burial is counted as the first day of Shivah provided the burial was completed before sunset. The morning of the seventh day is considered a full day. During the week days of Shivah, the mourners remain at home. They sit on low stools and wear slippers of felt or cloth. During Shivah, morning and evening services are conducted in the home except on the Sabbath. On the Sabbath and Festivals, when mourning is prohibited, the mourners go to the synagogue. A memorial light burns in the home during the entire week of Shivah. During Shivah, mourners refrain from their customary occuptaion unless their livelihood is jeopardized. Such extenuating circumstances should be discussed with the Rabbi.

All visible signs of mourning are suspended on the Sabbath, on the Festival or on Hol Hamoed. However, on the Sabbath during the Shivah week, and on the Sabbath and Festival before a funeral, the mourner is not called to the Torah in the Synagogue service.

When a funeral was held the day before a Festival, and one hour of mourning was observed before the Festival, there is no Shivah.

Sh'loshim (The thirty day period of mourning). Sh'loshim begins on the day of the funeral and ends on the thirtieth day. Mourners do not take part in any festivity or amusement during Sh'loshim. This period of mourning is extended twelve months for a parent. The rent garment is worn during Sh'loshim. The grave of the deceased should not be visited during Sh'loshim. A public memorial service may take place only after Sh'loshim.

If one learns of the death of a relative within thirty days of such death, he observes Shivah and Sh'loshim. Whether for a parent or other relative, the mourner is to sit on the low stool for one hour immediately upon receiving the news.

If a funeral is held the day before a Festival, the Shivah is cancelled and the Sh'loshim, in the case of Pesah and Shavuot, is terminated fifteen days later, and in the case of Sukkot, Sh'loshim is terminated eight days later. If Shivah was completed before these Festivals, the period of Sh'loshim is cancelled.

When a death occurs on a Festival and the funeral is held on the second day of the Festival or on Hol Hamoed (intermediate days of Pesah and Sukkot) both the Shivah and Sh'loshim commence at the conclusion of the Festival. The last day of the Festival counts as one of the days of Shivah and Sh'loshim.

If the funeral was held the day before Rosh Hashanah and one hour of mourning was observed, there is no Shivah

and Yom Kippur ends the Sh'loshim. If mourning commences before Yom Kippur, there is no Shivah and Sukko ends the Sh'loshim.

Kaddish. Mourners recite Kaddish for the period of eleven months less one day. If a mourner's parents are living, out of respect to them he should not recite Kaddish for another relative. Some other member of the family should then recite Kaddish.

Yahrzeit. The anniversary of the death of a relative is observed by lighting a candle in the home for twenty-four hours from sunset to sunset, by appropriate meditations, by attending synagogue service, there to pray and to recite Kaddish. Amusements should be avoided on the day of Yahrzeit. It is customary in some congregations to memorialize the departed also on the Sabbath prior to the Yahrzeit. Some observe the anniversary as a fast day. It is customary to contribute to the synagogue and other causes in memory of the departed. As a tribute to the departed, part of the Yahrzeit day or evening should be devoted to the study of some religious text.

The Yahrzeit is observed on the anniversary of the day of death. When a burial does not take place on the same day of the death, only the first Yahrzeit is observed on the anniversary of the burial, but all subsequent Yahrzeits are observed on the anniversary of the day of death.

The Yahrzeit should be observed according to the Hebrew calendar. By consulting the current Hebrew diary,

the Yahrzeit date is easily ascertained. The Yahrzeit begins at sunset of the previous evening. If death occurs in the month of Adar of an ordinary year the Yahrzeit is observed on the first Adar of a leap year. If death occurs on the first Adar of a leap year, the Yahrzeit occurs on the first Adar of a leap year or on Adar of an ordinary year. If death occurs on the second Adar of a leap year, the Yahrzeit is observed on the second Adar of a leap year or on Adar of an ordinary year.

Clothing of the deceased. The clothing, shoes, hats, etc. of the deceased who did not die of a contagious disease, should not be destroyed if they are in good usable condition. They should be given to the needy.

Flowers in a house of mourning. Instead of sending flowers to the funeral or to the home, an acknowledgement of a gift to some synagogue fund, or a charitable cause in memory of the departed would be more in keeping with the spirit of Judaism.

Setting a tombstone. The time for setting a tombstone varies with different communities. Some prefer to set a tombstone on the Yahrzeit or during the week of the Yahrzeit.

ORDER OF ADDING NAME

The sages of the Talmud said: "Four things cause an evil decree passed on man to be cancelled; they are; charity, prayer, adding name, and change of action

(Rosh ha-Shanah 16b; Ta'anit 15a). Hence, the custom prevails to add to the name of a sick person, by means of casting lots, in this wise: a Bible is opened and the first name that appears on the page, providing it is a suitable one (one of our holy patriarchs), is given the sick person. In the special prayer for the sick, his old name as well as the new one are mentioned, but the new name is to be mentioned first.

LAWS AND ORDER OF CONFESSION

If it is perceived that the invalid is dying, the visitors should tactfully turn the conversation to the subject of confession (Shabbat 32a; Sifri ad Num. V,6; Maim. Teshubah I, 1; Yorek Deah CCCXXXVIII, 1), and should add: "Do not fear that evil may result, for many who have confessed became well and did not die, and there were many who failed to confess and died. On the contrary, as a reward for having confessed, your life will be prolonged. Moreover, all who confess have a share in the world to come" (Sanhedrin 43b; Maim.l.c; Yoreh Deah l.c.).

If the invalid is unable to confess verbally, he should be told to make a mental confession, and if he is able to speak but little, he should be told to say: "May my death to an atonement for all my sins." The invalid should also be reminded to ask pardon for all those against whom he had sinned, whether in money or by words. All of the above words should not be spoken in the presence of

ignorant persons, nor of women, nor of children, for it may cause them to shed tears and this may cause the sick person to become dejected (Sanhedrum l.c; Yoreh Deah l.c.; Kitzur Shulhan Arukh CXCIII, 13).

CONFESSION

Though traditionally, one does not think of confession as an aspect of Jewish tradition, there is, indeed, such a ceremony and ritual. From the Talmud (Shabbat 32A), we learn that when it is perceived that the person is dying, the visitors should sensitively turn the conversation that within the framework of this new direction, it should be said: "Do not fear that evil may result, for many who have confessed became well and did not die, and there were many who failed to confess and died. On the contrary, as a reward for having confessed, your life will be prolonged. Moreover, all who confess have a share in the world to come" (Sanhedrin 43B).

If the person is unable to confess verbally, he is instructed to make a mental confession and atone for his sins.

The implication of this process is once again to reassure the person and the "other persons" that there is a reason for optimism in the future. Herein rests a possibility for reasserting a more precise viewing of the question of honesty with integrity. What are the responsibilities to the person who is dying as well as the

"other persons?"

LAWS CONCERNING A DYING PERSON, AND THE CARE TO BE TAKEN OF THE DEAD BODY

A dying person is to be considered as a living being in all respects. It is therefore forbidden to touch the body. The one who does touch the body is guilty of blood-shed (for it may accelerate the end) (Shabbat 151b; Semahot II, 3; Maim. Abel IV, 5: Yoreh Deah CCCXXXIX, 1). Even if the patient be a long time in a dying condition, and it causes great suffering to himself and to his next of kin, it is nevertheless forbidden to bring about, even in an indirect way, the acceleration of his death (Yoreh Deah l. c., gloss).

Although it is forbidden to touch a dying person, yet if the house wherein he lies is caught on fire, he must not be allowed to remain there, but must be removed therefrom; his saving has even preference over the saving of sacred books (Kitzur Shulhan Arukh CXCIV,2).

They who stand by the dying person must take precautions that no part of the dying man's body projects out of the bed. They must therefore place some articles of furniture around the bed, so that the patient be unable to stretch a hand or a foot outside thereof. Nevertheless, if they failed to take the necessary precautions, and the patient did project one of his limbs, it is forbidden to touch it for the purpose of putting same in the bed.

(Sifte Kohen ad Yoreh Deah CCCXXXIX, note 4; beer Heteb ad i.c., note 5).

From the moment a person is in the grip of death, it is forbidden to leave him, so that his soul may not leave him while he is all alone. It is a religious duty to stand by the person at the time his soul is about to separate from his body. Those present at the time of the soul's departure should not engage in idle or frivolous conversation, God forbid, but should either discuss topics of the Torah or recite chapters from the Psalms (Yoreh Deag CCCXXXIX, 4; Hokhmat Adam).

It is forbidden to do anything in connection with the funeral before life has departed (Shabbat 151z; Maim. Abel IV, 5; Yoreh Deah CCCXXXIX,1).

After the departure of the soul, a physician should be consulted. If there is no physician on hand, they should hold a light feather near his nostrils, and if it does not stir, it is a clear indication that he is dead. Thereupon the windows of the house are to be opened, and those next of kin who are to observe mourning, should recite the prayer "Tsiduk Haddin," and pronounce the benediction, including the Divine Name and title of King, thus:

"Praised be Thou, O Lord our God, King of the universe, the Judge of Truth."

After this they rend their garments. Those present at the separation of the soul from the body, who are not

obligated to observe mourning should say: "Blessed be the Judge of truth," not including the Divine name and the title of King (Yoreh Deah l.c.,3; Hokmat Adam).

All present at the departure of the soul are required to rend their garments. The duty of rending the garments by those who are not obligated to observe mourning may be discharged by rending the garment slightly, even at its side or its hem (Moed Katan 25a; Maim, Abel IX, 11: Yoreh Deah CCCXL,5; Kitzur Shulhan Arukh CXCIV,6).

The eyes of the dead person should be closed. If there are sons present, one of the sons should do it; and if there is a first-born son, it is his duty to do so (Maim. Abel IV,1; Yoreh Deah CCCLII,4: Hokhmat Adam CLVII,9).

Then they must wait at least one full hour, and place the corpse on the floor. No bedding or mattress should be placed underneath the corpse, but either straw or anything that is not subject to the law of uncleanliness. The corpse is covered with a blanket or a robe. The corpse should be placed so that the feet are toward the door of exit, and lighted candles should be placed at the head. (Derekh ha-Hayyim).

While carrying the deceased from the bed to be placed on the ground, care should be taken to keep him well covered, so that no part of the body be exposed (Maabur Yabbok; Kitzue Shulhan Arukh CXCIV,8).

The corpse must be constantly watched and never left alone. The one who watches the dead is exempt from reading

the Shema, from reciting the prayers, and from observing any of the precepts of the Torah, for he who is engaged in the performance of one religious duty is exempt from performing another at the same time. If, however, there are two watching the corpse, one should watch and the other should read the Shema and recite the prayers (Berakhot 18a; Maim. Keriat Shema IV,3; Yoreh Deah CCCXLI,6; Orah Hayyim LXXI,3).

It is forbidden to partake of any good in the room where the deceased lies, unless a partition is erected. Even eating fruit or drinking water is forbidden. It is likewise forbidden to pronounce there any benediction (Moed Katan 23b; Maim. Abel IV,6; Yoreh Deah CCCXLI,1).

It is forbidden to handle the corpse on the Sabbath, even if it is for the purpose of performing some religious duty. The handling may be done by a non-Jew if the next of kin consent thereto (Orah Hayyim CCCXI,2,gloss;Beet Heteb and Orah Hayyim l.c., note 9).

LAWS CONCERNING THE TEARING OF A RENT IN THE CLOTHES

One who had lost his next of kin for whom he is required to observe mourning, must perform the ceremony of tearing a rent in his clothes. This ceremony must be performed while standing; if performed while sitting, the obligation is not fulfilled, and it must be performed again while standing. It is best to tear a rent in the clothes before the coffin is closed when one's sorrow is still

intense (Moed Katan 24a, 20b; Maim. Abel VIII,1,3; Yoreh Deah CCCXL,1).

The clothes must be rent near the neck, in the front thereof, and it must not be rent crosswise but lengthwise, and in the cloth of the garment and not at its seam (Moed Katan 26b; Maim.l.c., 1; Yoreh Dean l.c., 2,20).

For all other next of kin it suffices to tear a rent in the external clothes only a hand-breadth, but for a father or a mother all the clothes must be rent opposite the heart, with the exception of the under-shirt; the upper garment which is worn only occasionally, i.e., the overcoat, need not be rent. If one failed to tear a rent in all the clothes as required, one does not fulfill his religious duty (Moed Kata 22b; Maim.l,c.,3; Yoreh Deah l.c., 9,10.).

It is the prevailing custom to tear the rent on the right side of the garment for all other next of kin, but on the left side for one's father or mother. Nevertheless, if this were overlooked, it does not invalidate the fulfillment of the duty (Sifte Kohen and Ture Szhab ad Yoreh Deah l.c.).

In the case of any other next of kin, if the mourner changes his clothes during the seven days of mourning, he need not tear a rent in the garments he now puts on. If, however, he who mourns for a father or mother, changes his garments on a week-day, during the seven days of mourning, he must rend the garments he puts on (Moed Katan 24a; Maim. l.c., Yoreh Deah l. c.).

In honor of the Sa-bath, the mourner may change his clothes, and put on other every-day garments, but he must not wear the garments that were rent. However, he is not allowed to put on such garments as are usually worn by him on the Sabbath. If he have no other weekday clothes than those that contain the mourning sign, he must turn the rent inside (Moed Katan l. c.; Maim. Abel X,1: Yoreh Deah CD,1).

For all other next of kin, if the mourner did not hear of their death until after thirty days, he need not rend his garments, but for a father or a mother he must rend the garments he is wearing at the time he hears of their death. He need not, however, rend the garments which he puts on thereafter (Yoreh Deah CCXL, 18).

In the case of other next of kin, the rent may be basted together after the seven days of mourning, and completely sewed up after the thirty days, but in the case of mourning for a father or a mother, the rent may be basted together after thirty days, and never sewed up. A woman may baste it together at once (Moed Katan 22b; Maim. Abel IX,1' Yoreh Deah CCCXL, 15).

The intervention of a Festival cancels the obligation of wearing the rent garments during the thirty days. Therefore, if a Festival occurs during the first thirty days of mourning, the mourner may sew up the rent on the eve of the Festival after the Afternoon Service, in the case of all other next of kin; and he may baste it together if he mourns for a father or a mother (Sifte Kohen ad Yoreh

Deah i.c., Kitzur Shulhan Arukh CXCV,9).

If an infant dies within thirty days of its birth, and it cannot be ascertained whether it was of mature birth, even if it dies on the thirtieth day, even if its hair and nails are grown, no garments should be rent for its death, because it may be an abortive child. If it dies after the thirtieth day, (say) on the thirty-first, even at an earlier hour than on which it was born, the garments must be rent for its death. If it is definitely known that it was born in the ninth month, the garments should be rent even if it dies on the day it was born (Shabbat 135b; Niddah 44b; Maim. Abel 1,6,7; Yoreh Deah CCCLXXIV,8

It is forbidden to rend the garments for the death of him who had committed suicide (Semahot II,1; Maim. Abel I,11; Yoreh CCCXLV,1).

On the Intermediate Days of a Festival, it is the prevailing custom not to rend the garments, whether the burial had occurred thereon, or whether one had learned of the death on that day, except for a father or a mother. But if one's father or mother had died on the first days of a Festival, when the rending of the garments cannot take place, the rent shall not be made on the Intermediate Days of the Festival, but should be postponed until the whole Festival is over when the period of mourning begins (Yoreh Deah CCCXL,31,gloss).

LAWS CONCERNING AN ONAN

One who loses by death one of his next of kin for whom he is bound to observe mourning, it termed onan from the time death occurred until after the interment (Beer Heteb ad Yoreh Deah CCCXLI, note 1). The onan may not partake of food in the room where the dead is lying. Even if the onan happens to be in another city, he may not partake of an elaborate meal. He may neither eat meat nor drink wine (Moed Katan 23b; Maim. Abel IV,6; Yoreh Deah CCCXLI,1).

An onan is exempt from observing all precepts, because of the honor due the dead. He may not pronounce the benediction before eating bread, nor may he recite Grace after meals. Even when others eat and pronounce the benedictions, he may not respond amen. But the onan must observe all prohibitive laws, be they even enforcable only by Rabbinic enactment. Therefore, if he desires to eat bread, he must wash his hands, but he may not say the benediction, "Concerning the washing of hands." On arising in the morning, he must wash each hand three times, as required by law, but he may not pronounce the necessary benediction (Moed Katan l.c.; Maim. l.c.; Pithe Teshubah ad Yoreh Dean l.c., note 4).

The mourner may not remove his shoes before the interment, but he is permitted to leave the house to make provisions for the burial; he is however forbidden to sleep or sit on a chair or a bed, and to have sexual intercourse (Yoreh Dean CCCXLI,5).

An onan is forbidden to bathe, anoint himself with oil, participate in joyous celebrations, greet friends, have his hair cut, and to study the law. He is forbidden to do any work, and he may not have his work done by others, although the abstinence from work may result in loss. In the event the loss is very great, he should seek the advice of the learned in the Law (Yoreh Deah l.c.).

If the onan is in another city, and in the place where the dead is found there are other relations who are required by law to observe mourning, the former need not observe the laws concerning an onan. But if there are no next of kin where the dead body lies, he is subject to all the laws relating to an onan (Sifte Kohen ad Yoreh Deah CCCXLI, note 5).

If death occurs on the Sabbath, and the law prohibits the burying of the dead on that day, the mourner is not subject to the laws relating to an onan. He is permitted to partake of meat and wine, and is obliged to observe all precepts, but is not permitted to have sexual intercourse (Moed Katan 23b; Maim. Abel IV, 6; Yoreh Deah CCCXLI,1), or to study the Law because these things are done in privacy (and therefore forbidden) (Magen Abraham to Orah Hayyim DXLVIII, note 8). If he is a reader in a synagogue, he may not officiate, unless there is no other person available to replace him. If the dead is his father or his mother, he may say the kaddish, providing there are no other mourners present in the synagogue.

If there are other mourners, he should not say the kaddish before the burial takes place (Pithe Teshubah ad Yoreh Deah CCCXLI, 2; Laws of Onan by Margolit).

On the Sabbath, shortly before evening, the onan should read the shema without reciting the benedictions. He should neither read the Evening Service nor perform the habdalah ceremony. He is permitted to partake of food without reading the habdalah (Yoreh Deah CCCXLI, 2: Ture Zahab ad Orah Hayyim LXXI, note 4).

If death occurs on a Friday afternoon, at an hour when it is impossible to have the burial before the arrival of the Sabbath, the mourner is required to read the Afternoon Service on that day (Laws of Onan by Margolit; Kitzur Shulhan Arukh CXCVI,17).

If death occurs on the first day of a Festival, and the mourner desires that the burial be carried out on that day by a gentile, he becomes immediately subject to the laws of an onan. If death occurs on the second day of a festival, when the mourner himself is permitted to bury the dead, he immediately becomes subject to the laws of an Onan (Yoreh Deah CCCSLI,1).

On the eve of the fourteenth of Nisan, an onan should appoint an agent to make search for leaven, but he must himself recite: "All leaven," etc. (Laws of Onan by Margolit; Kitzur Shulhan Arukh CXCVI, 17).

LAWS RELATING TO THE PURIFICATION (Taharah) AND THE SHROUDS

The rite of washing the corpse before burial should not be commenced before the shrouds are ready (Dereh ha-Hayyim).

It is the custom to make the shrouds of fine white linen, but they most not be too costly (Moed Katan 27b; Maim. Abel IV,1: Yoreh Deah CCCLII, 1,2).

Neither a hem nor a knot of any sort may be made while sewing the shrouds, or when dressing the dead (Minhage Yeshurun CCX; Hokhmat Adam).

The shrouds should consist of no less than three garments: The shirt, the breeches, the overgarment with the girdle. White stocking should be put on the legs of the corpse and a white cap on his head (Sefer ha-Hayyim).

A dead male should be wrapped in a talith with fringes, and one of the fringes should be rendered unfit for religious use, to indicate that the dead are exempt from fulfilling the Law. The better procedure, however, is, that instead of rendering one fringe unfit, to put one fringe in the corner pocket of the talith when the body is already in the grave. If the deceased leaves a costly talith in which he prayed during his lifetime, it is not proper to wrap him in an inferior talith, for a person is anxious to be buried in the talith in which he prayed during his lifetime. (Yoreh Deah CCCLI,2: Hokhmat Adam; Kitzur Shulhan Arukh CXCVII,1.)

The body of the dead female must be attended to only by females. In the place of the talith, an additional over-garment is placed on her shoulders (Semahot XII; Yoreh Deah CCCLII,3; Derekh ha-Hayyim).

When beginning the washing of the body, respect must be shown to the dead as though he were alive. No idle conversation should be indulged in in the presence of the dead, but it is permissible to speak of the necessary preparations for the funeral. The body must not be moved from place to place by a single person, but it must be performed by two or more persons, to prevent the corpse's legs and hands from being suspended (Derekh ha-Hayyim; Sefer ha-Hayyim).

Purification of the body: The entire body, including the head, should be washed with warm water. The fingers and toes, as well as all other part of the body, should be thoroughly cleansed. The hair of the dead should be combed (Yoreh Deah CCCLII,4; Hokhmat Adam).

The corpse must be entirely enveloped in a white sheet while being cleansed, and the body should be washed, while half covered, by holding up the ends of the sheet. The washing must be started from the head, and then downward to the feet (Sefer ha-Hayyim).

Care should be taken not to place the body with its face downward, as that is a degrading position, but it should be inclined, first on one side, and then on the other (Yoreh Deah CCCLII,4: Kitzur Shulhan Arukh CXCVII,2).

After the body has been thoroughly cleansed, it is placed in a standing position on the ground or upon straw, and nine kabbim of water should be poured over the head so that it runs down over the entire body. This last operation constitutes the real purificaion (taharah) (Kitzur Shulhan Arukh CXCVII,2). While the water is poured over the corpse, the mouth should be covered by hand or otherwise to prevent the water from running into it. The body is then thoroughly dried (Dereh ha-Hayyim).

Concerning the measure of nine kabbim there is a diversity of opinion. To comply with the law, it is therefore best to take about twenty-four quarts of water. It is not necessary that the water be poured out of one vessel, as the contents of two or even three vessels may be combined to make up the required quantity. It is, however, necessary to commence pouring out the contents of the second vessel before the first is finished, and from the third before the second is finished. Even when pouring the water out of one vessel, the flow must not be interrupted. Four vessels cannot be combined to be counted as one, even if the water is poured out from all four simultaneously (Magen Abraham ad Orah Hayyim DCVI, note 9; Kitzuer Shulhan Arukh CXCVII,3).

Then an egg is beaten with a little wine (the beating should be done in the shell of the egg), and the head of the dead washed therewith (Yoreh Deah CCCLII,4, gloss; Kitzur Shulhan Arukh l.c., 4).

Care should be taken not to allow the fingers of the

dead man's hands to remain closed (Kitzur Shulhan Arukh l.c., 5).

After having been cleansed, the corpse should not be allowed to remain in the place where the rites of purification had taken place, but it must be placed inside the house towards the door (Kitzur Shulhan Arukh l.c.,6; Ma'abar Yabok; Sefer Matamim 14).

The board upon which the corpse was washed must not be turned over (Kitzur Shulhan Arukh l.c).

One must not kiss his dead children, because it is dangerous (Kitzur Shulhan Arukh l.c.,7).

If one falls and dies instantly from wounds from which blood issued forth, and there is apprehension that the blood that sustains life was absorbed in his clothes, his body should not be ritually cleansed; he should be interred with his garments and shoes, but above the garments he should be wrapped in a sheet which is called Sobeb. It is customary to dig up the earth at the spot where he fell, and if blood happens to be there, all that earth upon which blood was found should be buried with him. Only the garments which he wore when he fell are to be interred, but if there were blood-stains on other garments which he did not wear at the time, or if he was placed upon pillows and sheets whilst the blood was flowing, all these need not be buried with him, but they must be thoroughly washed until no trace of blood remains, and the water should be poured into his grave. If, however, the one who fell and died did not bleed

at all, his garments must be removed, and his body must be cleansed and dressed in shrouds, as is done in the case of all other dead persons (Beer Heteb ad Yorek Deah CCCLXIV, note 7; Hokhmat Adam CLVII,10; Kitzur Shulhan Arukh CXCVII,9).

If blood has flown from the injured body and his clothes were removed, and thereafter he recovered and lived for a few days and then died, he must be cleansed and dressed in shrouds. Even if his body is stained with the blood which issued forth from him, he should be cleansed, for the blood lost during his life-time is not to be regarded; we are only concerned with the blood which one loses while dying, for it is likely that this was the blood that sustains life, or it is possible that the blood sustaining life has become mixed therewith (B-er Heteb l.c.; Hokhmat Adam l.c.; Kitzur Shulhan Arukh l.c., 9).

If a woman dies while giving birth, the laws applying to a slain person apply also to her, and if it is known that she had lost much blood, she must not be cleansed. If the blood had already ceased flowing and then she died, she should be treated as required by law in the case of all other dead persons. In many communities it is customary to cleanse the body of any woman that dies at child-birth; and there are also many other customs prevailing in such cases; such customs should be observed without interference (Beer Heteb l.c.; Kitzur Shulhan Arukh l.c., 11).

It is forbidden to derive any benefit from either

the dead body or the shrouds, whether it be of a Jew or a non-Jew. Likewise ornamental objects which are attached to the corpse, as for instance, a wig tied to, or woven into the hair, or artificial teeth, must be interred with the body, and no one is permitted to derive any benefit therefrom. Such ornamental objects that are not attached to the body, one is permitted to use. In any event use may be made of articles which are not reckoned as a part of the body, such as jewelry and clothes (Sanhedrin 47b-48a; Erukhin 47b; Maim. Abel XIV,11; Yoreh Deah CCCXLIX, 1,2).

LAWS CONCERNING THE REMOVAL OF THE CORPSE, AND THE FUNERAL

When the corpse is being removed from the house, no one is permitted to walk out of the house ahead of the corpse. The pall-bearers, however, who are obliged to leave the house first in order to carry the coffin, need not be particular in this matter (Kitzur Shulhan Arukh, CXVII,8).

It is forbidden to let the dead body remain over night, for it is written (Deut. XXI,23): His body shall not remain all night. . . but thou shalt in any wise bury him that day." However, one may leave the body over night for the sake of honoring the dead, e.g., to procure a coffin, shrouds, or to await the arrival of relatives or of hose who will deliver the funeral orations; as the Torah forbade a delay in burial only when it leads to the contempt of the dead, similar to the case of the one that was hanged,

but not when the delay is for the purpose of doing him honor (Sanhedrin 46a; Maim. Abel IV, 8; Yoreh Deah CCCLVII,1). If a dead man is found whose identity was not established, it is permissible to let the body remain unburied over night until witnesses can appear to identify the corpse, or until his wife can come to identify him (Pithe Teshubah ad Yoreh Deah l. c., note 3).

While it is praiseworthy to hasten to bring one's next of kin to rest, it is despicable to hurry the burial of one's father or mother because over the loss of them one must mourn and weep vehemently, unless it is on the day preceding the Sabbath or a Festival, or if rain is coming down the bier (Moed Katan 22a; Maim. Abel IV, 7,8: Yoreh Deah CCCLVII,2).

If there are two persons to be interred, the one who dies first shall be taken out first for burial. After the interment of the first, those present at the burial should not stand by the grave in line nor pronounce the benediction of mourning nor that of consolation, so as not to delay the burial of the second deceased (Yoreh Deah CCCLIV; Kitzur Shulhan Arukh CXVIII, 5)

If one of the two dead persons is a learned man and the other ignorant, the former should be brought to his rest first, even if the latter is dead first. If there be a man and a women, the woman should be brought to rest first, even if the man died first (Yoreh Deah l. c.).

It is a meritorious duty to accompany the dead to his

grave. He who sees the funeral escort pass by and fails to join the procession, is considered like one mocking and sneering at the poor, and deserves to be excommunicated therefor. It is a duty devolving upon every person to accompany the dead at least the short distance of four cubits (Berakhot 18a; Yoreh Deah CCCLXI,3).

Even the study of the Torah must be interrupted for the purpose of accompanying the dead to his grave(Ketubot 17a; Maim. Abel XIV, 9; Yoreh Deah CCCLXI, 1).

When the funeral escort arrives within thirty cubits (paces) from the grave, they should halt with the coffin every four cubits, so that they can make seven halts (indicative of seven times "vanity"mentioned in Ecclessiastes; the seven portals of Hell, etc.). On the day when the Prayers of Supplications (tahanun) are not recited, the halts are not to be made (Yoreh Deah CCCLVIII,2, gloss; Kitzur Shulhan Arukh CXCVIII, 12).

The burial as required by law is the interment of the dead body in the earth itself. In many localities, however, it is customary to place the dead in a coffin made of boards and to inter him thus; as it is unlikely that there should not be any aperture at all in the coffin, this manner of burial fulfills the requirement of the Law (Yoreh Deah CCCLXII, 1: Beer Heteb ad Yoreh Deah 1. c., note 1).

The corpse is laid in the grave upon its back, with the face upward (Yoreh Deah 1. c., 2).

The dead should not be buried close to each other.

They must be separated by a partition which can stand by itself without a prop, which is a thickness of no less than the size of six fingers; if possible it is best to have a space measuring six handbreadths between graves (Yoreh Deah l. c., 3).

Two coffins shall not be interred on upon the other unless there are not less than six hand-breadths of earth between them (Yoreh Deah l. c., 4).

It is the established custom not to take from the hand of one's neighbor a hoe or pick-ax or shovel with which the burial is performed; but the one using it lays it down, and the other one takes it up (Hokhmat Adam CLIX, 30; Kitzur Shulhan Arukh CXCIX, 7).

Those present at the funeral form themselves into two rows, through which the mourners pass, and they recite the folloing (Otzar Dinim Uminghagim, Nihum Abelim):
May the Omnipresent comfort you together with all the mourners of Zion and Jerusalem.

When about to leave the burial grounds, it is customary for the people to pluck some grass and throw it behind their back saying (Ps. CIII,14): He remembereth that we are dust.

This custom is symbolical of the resurrection of the dead, in accordance with that which is written (Ps.LXXII,16): "And may they blossom out of the city like grass of the earth." They should then wash their hands (Yoreh Deah CCCLXXVI, 4; Beer Heteb ad l.c., note 4). For this ablution

a river cannot be used, the use of a vessel is required (Kitzur Shulhan Arukh CXCIX, 10). One should not take the vessel from another who had washed his hands, but the latter should put it down and then the former should take it; and the hands should not be dried with a towel or any other cloth (Kitzur Shulhan Arukh l.c.).

LAWS CONCERNING BURIAL ON A FESTIVAL

On the first day of a Festival an Israelite should not be engaged in the burial of the dead; even if it is impossible to have the burial attended to by a non-Jew and there is danger that decay may set in, a Jew is not permitted to bury the dead on the first day of a Festival. If it is possible to obtain a non-Jew to dig the grave and to cut the boards or make a coffin, and also to sew the shrouds if need be, then an Israelite is permitted to dress the body, to heat water, and cleanse the body, and to carry it out and place it in the grave, but filling the grave with dirt should be done by a non-Jew. If possible, care should be taken to cleanse the body without the use of a cloth, so that they may not violate the law by wringing the water out of the cloth (Besah 62; Maim. Yom Tob I, 23; Orah Hayyim DXXVI, 1; Kitzur Shulhan Arukh CC,1).

On the second day of a Festival, even of Rosh Hashanah, if it is possible to have all of the aforementioned duties performed by a non-Jew without causing delay, a non-Jew should carry out the same, while the other preparations

mentioned above may be performed by Israelites. It is also permissible to use garments and sheets in performing the purification; care, however, should be taken not to wring out the water with the hands. If it is impossible to have the aforementioned duties performed by a non-Jew, an Israelite is permitted to make all the necessary preparations for the burial, as though it were a week-day, inasmuch as the Rabbis have compared the second day of a Festival with a week-day in the matter of preparing the dead for burial. If, however, it is possible to obtain ready-made shrouds, it is preferable to use those, in order to avoid the necessity of sewing new ones. It is permissible to attend to all matters relating to the dead only when the burial is to take place that same day; if not, it is forbidden to make the slightest preparation for the burial; it is even forbidden to handle the body (Bezah l. c.,; Maim. l. c.; Orah Hayyim l. c., 4: Beer Heteb note 4; Kitzur Shulhan Arukh l. c., 3).

The Rabbis have considered in this regard the second day of a Festival like a week-day because of the honor due to the dead. It is, however, forbidden to do anything else not directly connected with the burial; hence it is forbidden to fix the price of the shrouds unless it is impossible to obtain them otherwise. Gravediggers are not allowed to take any remuneration for their work on a Festival. If they refuse to work without pay, they should be paid, but they will have to render an account of their conduct in the future. The holy brotherhood should not take any money for

for the grave, on a Festival, but they may accept pledges without stipulating the amount to be paid (Kitzur Shulhan Arukh l. c., 4).

If there is no Jewish cemetery in town, although there is a place where a dead person may be buried, it is nevertheless permitted to convey a dead body on the first day of a Festival through a non-Jew, and on the second day of the Festival through an Iraelite, to a place where it can be buried in a Jewish cemetery. But if it is not intended to bury him on that day, an Israelite is forbidden to convey the body on a Festival for the purpose of having it buried after the Festival (Orah Hayyim DXXVI, 4; Kitzur Shulhan Arukh CC, 4).

On the first day of a Festival it is permissible to accompany the dead only within the Sabbath-limit and not beyond that. On the second day of a Festival it is permissible to go beyond the Sabbath-limit and to return home on the same day. It is forbidden, however, to ride on an animal in order to accompany the dead on a Festival, even on the second day thereof. This rule applies also to those who are legally bound to observe mourning. The gravediggers, are permitted to ride on the second day of a Festival, if it is impossible for them to walk; nevertheless, they should not ride through a city (Orah Hayyim l. c., 6, 7,; Beer Heteb a. l., note 14).

With regard to an infant over thirty days old, if it is known that it was not an abortive child, the same laws

apply to him as to any other dead person. If it is a male child whose circumcision has for some reason been postponed, he should not be buried on the first day of a Festival, even if decay is setting in, for it is necessary to remove the foreskin, and this cannot be done by a non-Jew. The body should be kept until the second day of the Festival when the body is interred after removing the foreskin (Kitzur Shulhan Arukh CC,8).

If an infant dies, and it is doubtful whether or not it was abortive, it should not be buried on the first day of a Festival. It should be kept until the second day of the Festival for burial by a non-Jew. If the body is in a state of decay, it should be buried by a non-Jew on the first day of a Festival. If the child dies on the second day of a Festival, it should be buried that very day by a non-Jew. If it is an uncircumcised male child, although in a state of decay, he should not be buried even by a non-Jew on the second day of a Festival. He should be kept until after the Festival, when the foreskin is removed and the body is interred (Orah Hayyim DXXVI, 10; Kitzur Shulhan Arukh CC,9).

On the Sabbath and on the day of Atonement no one should attend to the dead, not even through the aid of a non-Jew (Orah Hayyim l. c., 3).

On the Intermediate Days of Festivals the dead should not be conveyed to the cemetery before the grave is ready to preclude the halting of the bier (Orah Hayyim DXLVI, 1;

Yoreh Deah CDI, 1).

LAWS CONCERNING THE MEAN OF CONDOLENCE

On the first day of mourning, the mourner is not permitted to eat the first meal of his own food. It is, therefore, a religious duty devolving upon his neighbors to supply the mourner with food for the first meal, which is known as the Meal of Condolence (Moed Katan 27b; Semahot V, 23; Maim, Abel IV, 9; Yoreh Deah CCCLXXVIII, 1; Kitzur Shulhan Arukh CCV, 1).

If the mourner desires to abstain from food until nightfall, inasmuch as the first day has passed, he is permitted to eat the first meal of his own food. It is, therefore, proper for one that lives by himself in a village and has no neighbors who will send him food for the meal of condolence, to fast until nightfall; nevertheless, if he is unable to fast, he is not obliged to suffer, and he is allowed to eat his own food (Yoreh Deah CCCLXXVIII, 3; Kitzur Shulhan Arukh CCV, 2).

A married woman is not allowed to take the first meal of her husband's food, for inasmuch as it devolved upon him to support her, it is considered as her own food (Yoreh Deah l. c., 2).

To women in mourning, the meal of condolence should not be supplied by men but by women (Yoreh Deah l. c.).

If the burial takes place at night, and the mourner desires to eat during that night, he is forbidden to eat of

his own food. He should be provided with food for the meal of condolence. Should he not desire to eat during that night, he is forbidden to eat the first meal of his own food during the following day, because the day follows the preceding night, and it is therefore his first day of mourning until sunset (Pithe Teshubah ad Yoreh Deah CCCLXXV-III, note 2; Kitzur Shulhan Arukh CCV, 6).

If the burial takes place on a Friday after the ninth hour of the day, the mourner should not be served with a meal of condolence in deference to the Sabbath. The mourner should abstain from eating anything until the evening (Yoreh Deah CCCLXXVIII, note 5: Kitzur Shulhan Arukh CCV, 6).

If the dead is buried on a Festival, the meal of condolence is not to be served to the mourner. If the burial takes place on the Intermediate Days of a Festival, the Mourner should be served with the meal of condolence (Yoreh Deah CDI,4).

After the meal of condolence, Grace is recited, and in place of, "And rebuild Jerusalem," the following words of consolation are interpolated (Berakot 46b; Maim. Berakot II, 8; Yoreh Deah CCCLXXIX 1, 2; Beer Heteb a. 1., note 2).

LAWS CONCERNING THE SEVEN DAYS OF MOURNING

One is obliged to observe the rite of mourning on the death of the following seven next of kin: One's father, mother, son, daughter, brother, and sister, whether from the

father's side or mother's side, a wife, and a husband (Moed Katan 20b; Maim. Abel II, 1).

For the death of a child that did not live thirty days, one need not observe the rite of mourning (Shabbat 135b; Maim. Abel 1, 6; Yoreh Deah CCCLXXIV,8)

A minor, less than thirteen years old, is not obligated to observe the rite of mourning (Beer Heteb ad Yoreh Deah CCXL note 28).

The period of mourning begins as soon as the dead is buried and the grave is filled up with earth (Moed Katan 27a; Maim. Abel I, 2: Yoreh Deah CCCLXXV,1).

During the seven days of mourning cohabitation is forbidden (Moed Katan 21a; Maim. Abel V, 1; Yoreh Deah CCCLXXX, 1). It is also forbidden to wear leather footwear (Yoreh Deah CCCLXXXII,1; Kesef Mishneh to Maim. Abel V, 6).

During the first three days of mourning, the mourner is not allowed to do any work, even if he is poor and is supported by charity. From the fourth day on, if he lacks food, he may do work privately in his home. But the sages said: "May poverty overtake his neighbors, who forced him to do work," for it is their duty to provide for the poor, especially during the period of mourning (Moed Katan 15b; Maim. Abel V, 8; Yoreh Deah CCCLXXX,2).

If the work be very urgent, and the mourner might sustain a loss (by not doing it), he should consult the ecclesiastical authorities (Yoreh Deah l. x., 5; Kitzur Shulham Arukh CCCVIII, 3).

A mourner may accept work to be done by him upon the expiration of the period of mourning provided he neither weigh nor measure the same, as he would do at other times (Yoreh Deah l. c., 17, gloss).

Domestic occupations are not included in the work which a mourner is forbidden to do; thus, it is permissible for a woman in mourning to bake and cook, and to attend to all her domestic duties. She is, however, forbidden to do work that is not actually necessary (Semahot XI; Yoreh Deah CCCLXXX, 22).

During the seven days of mourning, the mourner is forbidden to bathe his body. He is permitted to wash his face, hands and feet with cold water only. Bathing is permissible if only used for medicinal or hygienic purposes (Moed Katan 15b; Maim. Abel V, 4; Yoreh Deah CCCLXXXI, 1).

During the seven days of mourning the mourner is forbidden to anoint himself in the slightest degree for the sake of pleasure; however, for hygienic and especially medicinal purposes it is permissible (Maim. Abel V, 4: Yoreh Deah CCCLXXXI,2).

During the seven days of mourning, the mourner is not permitted to study the Torah, but he may study the books and laws concerning mourning; as, for instance, the Book of Job; the Treatise Semahot; the mournful parts of Jeremiah, and the laws relating to mourners (Moed Katan 21a; Maim. Abel V, 16; Yoreh Deah CCCLXXXIV, 1,4).

During the seven days of mourning, the mourner is

not permitted to go to the reading of the Law on a week-day. Even if the mourner is the only priest in the synagogue, he is forbidden to go to the reading of the Law (Yoreh Deah CCCLXXXIV, 2).

During the first three days of mourning, the mourner should neither greet anyone, nor should other people greet him. If others, unaware that he is in mourning, do greet him, he is not allowed to respond to their greetings; he should inform them that he is a mourner. After the third day and until the seventh he must not greet others, but he may respond to the greetings of people who, not knowing of his condition, do greet him (Moed Katan 16a; Maim. Abel V, 20; Yoreh Deah CCCLXXXV,1).

During the seven days of mourning, laughter and any kind of rejoicing is forbidden (Moed Katan 26b; Maim. Abel V, 20; Yoreh Deah CCCXCI, 1).

During the seven days of mourning, the mourner is not permitted to sit on a chair or bench he should sit on a low bench or stool. It is not obligatory for him to sit; he may either walk or stand. When people come to offer him condolence, he must sit down (Kitzur Shulhan Arukh CCXI, 1).

On the first day of mourning, the mourner is forbidden to wear tephilin, it matters not whether it be the day of death and burial, or of burial only. If the burial takes place at night, he is forbidden to wear tephilin the the following day. If death occurs on a Festival, he must put on tephilin on the first day after the Festival (Moed

Katan 15a, 21a; Maim. Abel IV,9; Yoreh Deah CCCLXXXVIII,1).

A mourner is forbidden to wear a washed garment, even a shirt, during the seven days of mourning, even if it is in honor of the Sabbath (Moed Katan 17b; Maim. Abel V 3; Yoreh Deah CCCLXXXIX, 1).

During the seven days of mourning, a mourner is forbidden to leave his house. If death occurred in his family, or if it occurred elsewhere and there are not enough people to attend to the bier and the burial, he is permitted to leave the house even on the first day. If he has to attend to a matter of great importance, as where his absence would involve a great loss, he is permitted to go out, but he should put dirt in his shoes (Yoreh Deah CCXCIII, 1, 2: Kitzur Shulhan Arukh CCXIV, 1).

No mourning should be observed for the death of him who had committed suicide (Semahot II; Maim. Abel I, 11; Yoreh Deah CCCXLV, 1). Part of the seventh day of mourning is reckoned as the entire day. If, therefore, the mourner observed mourning but one hour on the seventh day, he may thereafter do his ordinary work. If the seventh day of mourning falls on the Sabbath, mourning ceases immediately after the Morning Service, and the mourner needs no longer observe the rite of mourning in the evening (Moed Katn 19b; Maim. Abel VI, 12; Yoreh Deah CCCXCV, 1; Kitzur Shulhan Arukh CCXVI, 1).

On the Sabbath that occurs during the seven days of mourning, the mourner must observe all the rules regulating

his private life; thus, he is forbidden to have sexual intercourse or to bathe. He must not, however, observe any rites of mourning in public; therefore, before the recital of "A Psalm. A hymn for the Sabbath," he should put on his shoes, sit on a regular chair, and change his garment for one without the sign of mourning (Moed Katan 19a; 24a; Maim. Abel X, 11; Yoreh Deah CD, 1).

If the mourner is called to the reading of the Torah on the Sabbath, he must go, as his refusal would constitute a public observance of mourning. If the mourner is a priest and there is no other priest present in the synagogue, he should be called to the reading of the Torah; however, it is best that the mourner leave the synagogue before the Scroll is taken out from the Ark (Yoreh Deah CD, 1; Pithe Teshubah a. 1, note 4).

If the mourner has a son to be circumcised on the Sabbath, and it is customary that the father is called to the reading of the Torah, then he should be called, for should they abstain from calling him, it would constitute a public observance of mourning on the Sabbath. It is best, however, for the mourner to absent himself from the synagogue during the reading of the Torah (Pithe Teshubah ad Yoreh Deah CD, note 5).

The Sabbath day is included in the total of the first seven days of mourning (Yoreh Deah CD, 2).

A candle or a lamp should be kept burning for the

departed soul during the seven days of mourning, especially when the prayers are offered (Beer Heteb ad Orah Hayyim DXLVIII, note 1).

A mourner, during the seven days of mourning, should not officiate as Reader of the prayers for the congregation, unless there are no other people present capable of acting as such. If, however, he is in mourning for his father or his mother, it is customary to permit him to act as Reader, even though another person who is capable is present. It is the established custom that a mourner may not act as Reader on Sabbaths and Festivals during the entire year, unless there be no other Reader. If he had been accustomed to act as Reader before he had become a mourner, he may continue to do so under all circumstances (Kitzur Shulhan Arukh CCX, 5).

If the burial takes place on a Festival, or during the Intermediate days of the Festival, no rites of mourning should be observed until after the Festival. The foregoing rule of law refers only to the observance of mourning in public, for the mourner must observe mourning in private matters even on Festivals (Moed Katan 19b; Maim. Abel X8; Yoreh Deah CCCXCIX, 1; Orah Hayyim DXLVIII, 1,4).

After the Festival is concluded, the mourner should begin to count seven days of mourning, the last day of the Festival counting as one of the seven days, after which he should count six more days. Even the second day of Rosh Hashanah is included in the total of seven days (Yoreh Deah

CCCXCIX, 2; Kitzur Shulhan Arukh CCXIX, 6).

A Festival annuls the laws of the seven days of mourning; thus, if the burial took place the day before a Festival, and the mourner observed some of the rites of mourning, mourning ceases upon the advent of the Festival. Even if he has only taken off his shoes a short time before the Festival, the Festival annuls the mourning, and it is considered as though he had kept the entire seven days of mourning before the Festival (Moed Katan 19a; 20a, Maim. Abel X,3; Yoreh Deah CCCXCIX, 1).

Rosh Hashanah and the Day of Atonement are also considered as festivals with regard to the annulment of the seven days of mourning (Moed Katan 24a; Maim. l. c; Yoreh Deah l. c., 6).

If Purim occurs during the seven days of mourning, the mourner must observe on that day all the laws of mourning, and he is forbidden to witness any manner of festivity; but he may put on his shoes and sit on a regular chair (Yoreh Deah CDI, 7; Orah Hayyim, DCXCVI, 4, gloss; Beer Heteb a.l., note 7).

During the seven days of mourning it is proper to have a quorum of ten adult male persons come to the house of the mourners so that public prayers may be offered, and the mourners recite the kaddish for the dead. The mourner may be counted as one of the quorum of ten. In the house of the mourner we do not recite. Tahanum, erekh appayim, and lamnatzeah ya'ankah adonay; the verse, vaani zoth b'rithi

(contined in Ubah l'zion), is omitted; during the repetition of the shemoneh esreh ('amidah), the priests' blessing is omitted; so is omitted the verse tithkabel in the kaddish. After the service, Psalm XLIX is read; and on those days when the Prayers of Supplications (tahanun) are not read, Psalm XVI is read instead of XLIX (Yoreh Deah CCLXXVI, 3 gloss; Orah Hayyim CXXXI, 4; Ture Sahab a.l., note 15; Magen Abraham ad Orah Hayyim CXXXI, note 10; Beer Heteb ad Orah Hayyim CXXI, note 2; ad Orah Hayyim CCXCV, note 1; Meah Shearim Abel 73; Derekh ha-Hayyim).

During the seven days of mourning, no hallel should be recited in the house of the deceased, if there is a mourner present. If they pray in the house of the departed but there is no mourner present, or if they pray in the house of the mourner but death did not occur there, hallel should be recited even on the New Moon, but the mourner himself should not recite it. If the New moon occurs on the Sabbath, hallel should be recited with the congregation even in the house of the mourner, for on the Sabbath no public mourning is to be observed (Beer Heteb and Pithe Teshubah to Yoreh Deah CCCLXXVI, note 2).

LAWS CONCERNING THE THIRTY DAYS AND THE TWELVE MONTHS

During the first thirty days of mourning, the mourner is forbidden to wear his Sabbath clothes even on Sabbath. Needless to add that he is forbidden to put on new clothes.

One who mourns for a parent is forbidden, according to custom, to put on new clothes during the entire year. If, however, the mourner is need of new clothes, he should let someone else wear them first for two or three days (Yoreh Deah CCCLXXXIX, 3m gloss; Kitzur Shulhan Arukh CCXI, 10).

A mourner is forbidden to cut his hair during the first thirty days of mourning; it is immaterial whether it is the hair of his head or the hair of his beard. if he mourns for a parent he must abstain from cuttin his hair until he is rebuked by his friends. The custom prevalent with us is not to cut the hair the whole year, unless it is actually necessary; e.g., if his hair is a burden to him, or if he is amongst people of other beliefs, and he would be looked upon with disdain on account of his untrimmed hair. Under the above circumstances, the mourner may cut his hair, provided it is after the first thirty days of mourning (Moed Katan 14a, 22b; Maim. Abel VI, 3; Yoreh Deah CCCXC, 1, 4).

A mourner is forbidden to join in a circumcision feast or in a feast celebrating the redemption of the first born, or in a wedding feast, during the first thirty days of his mourning for his next of kin, and during the twelve months if he is in mourning for a parent; in an intercalated year twelve months are sufficient. If a religious feast is celebrated at the mourner's house, he is permitted to partake thereof; but if it is a wedding feast, he is not allowed to participate even if it is at his house.

(Moed Katan 22b; Maim. Abel VI, 6, 7; Yoreh Deah CCCXCI, 2, 3).

A mourner is not permitted to extend an invitation to others, or to be invited with others (Beer Heteb ad Yoreh Deah CCCLXXXV, note 3; Kitzur Shulhan Aruk CCXII,2), nor is he allowed to send gifts to others or to receive gifts during the first thirty days of mourning for any other next of kin; and this law applies to the period of twelve months when in mourning for a parent. Whether the above may be done on the Sabbath, depends upon the custom prevailing in the locality (Yoreh Deah CCCLXXXV, 3, gloss).

During the twelve months of mourning for one's parents, or during the first thirty days of mourning for any other next of kin, the mourner is not allowed to enter a house where a wedding feast is being celebrated, even if it is only for the purpose of listening to the benedictions that are recited on such occasions. He is, however, permitted to act as the best man escorting the groom under the nuptial canopy, to put on his Sabbath clothes for that purpose and partake of the feast, providing it is after the first thirty days of mourning (Yoreh Deah CCCXCI, 3, gloss).

A mourner is permitted to attend a wedding feast to act as a waiter, and in his own house he may eat whatever is sent him from the feast (l.c.).

It is customary for a mourner to change his place at the synagogue during the first thirty days of mourning. If one mourns for a parent, he should change his seat during

the whole year. The new place should be at least four cubits distant from his accustomed seat and further removed from the Holy Ark (Yoreh Deah CCCXCIII, 2, gloss; 4; Pithe Teshubah a.l., note 7).

A part of the thirtieth day of mourning is considered as a whole day; therefore, immediately after sunrise the mourner is relieved from observing the laws pertaining to the thirty days of mourning (Maim. Abel VI, 12; Yoreh Deah CCCXCV,1). If the thirtieth day occurs on the Sabbath, the mourner is permitted to bathe in warm water on Friday, in honor of the Sabbath; he may put on his Sabbath clothes, and resume his original seat in the synagogue; but he is not permitted to have his hair cut (Yoreh Deah CD, 2, gloss; vide Pithe Teshubah a. l., note 6' Kitzur Shulhan Arukh CCXVI,2).

With reference to the twelve months of mourning for one's parents, we do not adopt the principle that "a part of the day is considered as the whole day." On the contrary, it is the prevailing custom to include the Jahrzeit day, even if it occurs on the Sabbath, in the period of mourning, and all the laws relating to the twelve months must be observed thereon (Yoreh Deah CCCXCV, 3, and gloss; Beer Heteb a.l, note 3).

A Festival annuls the laws relating to the first thirty days of mourning; thus, if the mourner observed one hour of mourning (not necessarily a complete hour, as less than that also suffices) before the Passover, that hour is

considered equivalent to seven days which, together with the eight days of Passover, make a total of fifteen days. After Passover, he counts additional fifteen days to complete the mourning period of thirty days. If the mourner observed mourning for one hour before Pentecost, that hour is considered equivalent to seven complete days, and the first day of Pentecost is also considered as seven days, whilst the second day of Pentecost constitutes the fifteenth day of mourning, and the observance of fifteen days thereafter completes the thirty days' period. If the mourner observes one hour's mourning before the Feast of Tabernacles, that hour is counted as seven days which, together with the seven days of Tabernacles, makes a total of fourteen days; the festival of Shemini Azereth counts also as seven days, making it a total of twenty-one days; the day of Rejoicing of the Law is the twenty-second day, and the observance of eight additional days thereafter completes the mourning period (Moed Katan 19 a-b; 24 a-b; Maim. Abel X, 3, 4; Yoreh Deah CCCXCIX, 7, 8, 11).

If the mourner observes one hour of mourning before the New Year (Rosh Hashanah), the Festival annuls the seven days of mourning; and the Day of Atonement annuls the thirty days. If he observes one hour's mourning before the Day of Atonement, the latter annuls the seven days of mourning, and the Feast of Tabernacles annuls the thirty days of mourning (Moed Katan 19a; Maim. Abel x,3; Yoreh Deah CCCXCIX, 6, 9, 10).

If the burial takes place seven days before the Festival and the mourner observes the seven days of mourning before the Festival, the latter annuls the thirty days, even if the seventh day occurs on the day preceding the Festival (Moed Katan 19b; Maim. Abel X, 5; Yoreh Deah CCCXCIX, 3).

If the seventh day of mourning occurs on Friday, and a Festival occurs on that Sabbath evening, the mourner is permitted to wash himself, bathe, and to have his hair cut on Friday (Moed Katan l.c; Yoreh Deah l.c.,3).

If the mourner, either inadvertently or intentionally, fails to observe mourning before a Festival, or if he is unable to observe mourning because the burial takes place at the approach of night, he is not exempt from observing the first thirty days of mourning, as they are not annulled by the Festival, and he is subject to the same law which applies to the case where a burial takes place on the festival itself (Yoreh Deah l.c., 1).

All the foregoing laws referring to the annulment of the thirty days of mourning by reason of the intervention of a Festival are applicable only in case of death of any next of kin, but mourning observed for a parent is not annulled by a Festival (Maim. Abel X, 5; Yoreh Deah CCXCIX, 4).

LAWS CONCERNING "TIMELY" AND "DELAYED" NEWS

If one hears of the death of his next of kin, for whom he is required to mourn, within thirty days, even if on the thirtieth day, the tidings are called "timely," and he is obliged to rend his garments, and observe the seven days of mourning counting them from the day on which the tidings reached him. The period of the thirty days' mourning is also to be counted from the day on which he receives the news. The day on which the "timely" news reaches him is governed by the same laws as obtain on the day of burial. And the thirty-day period which is to be considered as constituting "timely" news, is to be counted from the day of interment and not from the day on which the death occurred (Moed Katan 20a; Maim. Abel VII, 1; Yoreh Deah CDII, 1).

If the news reaches him after thirty days have elapsed from the day of burial, the tidings are called "delayed," and he need not observe mourning for more than one hour. It is immaterial whether he receives the "delayed" news by day or by night; one hour's mourning is sufficient even for the death of one's parent. However, the usual mourning for a parent during the twelve months must be observed even if the tidings reached him after the expiration of twelve months, he need not observe mourning for more than one hour, and this is true even of those laws which are to

be observed during the twelve months (Moed Katan 20b; Maim. Abel VII, 1; Yoreh Deah CDII, 1).

One who received "delayed" news need not observe all the laws of mourning, it being sufficient for him to take off his shoes. If he happened to wear no shoes when the news reached him, he must do something else whereby it will be recognized that he is in mourning, e.g., to sit on the ground for one hour (Yoreh Deah l.c., 2).

If one receives "timely" news on the Sabbath, he should count the Sabbath as one day, and at the termination of the Sabbath he should rend his garments and count six more days of mourning thereafter (Yoreh Deah l.c., 7).

If one receives "timely" news on the Sabbath or a Festival, and at the termination of the Sa-bath or the Festival such news will become "delayed," he must abstain on such day from the private matters (from which a mourner must abstain on the Sabbath or a Festival), he should observe only one hour's mourning as though the tidings were "delayed" (Moed Katan 20b; Maim. Abel VII, 3; Yoreh Deah CDII, 5).

If one receives "timely" tidings on the Sabbath, and on that Sabbath night a Festival commences, inasmuch as he must abstain from private matters that are forbidden to a mourner on the Sabbath, the Festival that follows annuls the seven days of mourning (Yoreh Deah CD, 10; Beer Heteb a.l., note 8).

The meal of condolence is served to a mourner only

upon his receiving "timely" news. If one receives "timely" news on Sabbath, meal of condolence should not be served to him, but he should eat of his own food. He should not be provided with such a meal on the Sunday following, inasmuch as the day on which he heard the news has already passed (Yoreh Deah CCCLXXVIII, 11, 12).

If one receives "delayed" news on a Sabbath or on a Festival, he should not observe mourning even with regard to private matters; but at the terimination of the Sabbath or Festival, he should observe one hour's mourning, and that is sufficient (Yoreh Deah CDII, 6).

LAWS CONCERNING KADDISH AND JAHRZEIT

Many stories are related to the Midrashim telling of a son's saving his father or his mother from judgment by reciting the kaddish. The custom therefore prevails for a mourner to say kaddish (Yoreh Deah CCCLXXVI, 4, gloss).

Although the saying of the kaddish and the recitation of prayers are helpful to the parents, it is not the main thing; the principal thing is for the children to walk in the proper path, for thereby they obtain divine grace for their parents (Zohar Behukotai, end).

It is the prevailing custom to say kaddish no longer than eleven months in order not to make one's father and mother appear as evil-doers, for the punishment of the wicked is meted out to them during the first twelve months after death. In an intercalated year, the first Adar and

the second Adar are considered as two distinct months as regards the saying of kaddish (Eduyyot 11, 19: Rosh Hashanah 17a; Yoreh Deah CCCLXXVI, 4, gloss).

One having Jahrzeit and also one in his first thirty days of mourning takes precedence of the mourners who are observing the year of mourning; nevertheless, the latter, too, should be permitted to say some of the kaddishim (Yoreh Deah l.c.).

It is a religious duty devolving upon every person to fast on the anniversary day of the death of his father or mother, in order that he may be impelled to do repentance, to investigate his conduct and improve it, and in this way obtain Divine grace for his father and mother who will be elevated in Paradise (Yoreh Deah CDII, 12, gloss; Kitzur Shulhan Arukh CCXXI, 1).

The Jahrzeit is always to be held on the day the demise took place, even on the first anniversary. However, if three or more days elapsed from the day of death until the interment, the first Jahrzeit should be observed on the anniversary of the interment, and in subsequent years always on the anniversary of the death (Orah Hayyim DLXVIII, 8; Yoreh Deah CDII, 12, gloss; Beer Heteb a.l., note 11; Kitzur Shulhan Arukh CCXXI, 2).

If death occurs during an intercalated year either in the first or in the second Adar, then in an ordinary year the Jahrzeit must be observed on the like date in the month of Adar, but in a leap year it should be observed in that

particular month when death occured, whether in the first or in the second Adar. If death occurred in Adar of an ordinary year, then in a leap year, Jahrzeit should be observed, on Adar 1, and on the same date in the second Adar kaddish should be recited; but the mourner may not bar others from saying kaddish in the second Adar (Orah Hayyim DLXVIII, 7, gloss; Yoreh Deah CDII, 12, gloss; Kitzur Shulhan Arukh CCXXI, 3).

If the one who has Jahrzeit is unable to say kaddish, for instance when he is on the road, he may say kaddish at the Evening Service (ma'arib) following the day of the Jahrzeit (Kitzur Shulhan Arukh XXVI, 21).

If one is not certain of the day when his father or his mother died, he should select a certain day, which according to his opinion is the approximate date, and should observe that day as the Jahrzeit on which to say kaddish; but he may not encroach upon the rights of others with regard to the kaddish (Kitzur Shulhan Arukh CCXXI, 8).

It is customary to kindle a light on the eve of the Jahrzeit, which is kept burning for twenty-four hours. This practice is linked with the thoughtexpressed in Proverbs XX, 27: "The spirit of man if the lamp of the Lord" (Magen Abraham ad Orah Hayyim CCLXI, note 6).

DEDICATION OF TOMBSTONE

It is an ancient custom in Israel to set up a tomb-stone in honor of the departed at the head of the grave.

Our patriarch Jacob set up a monument on the grave of his wife Rachel, as it is written (Gen. XXXV, 20): "And Jacob set up a pillar upon her grave; the same is the pillar of Rachel's grave until this day." The tombstone is set up so that one should know where to pray, and also that the dead be not forgotten.

This custom is mentioned many times in the Talmud. In the days of the Talmud it had already been the established custom to engrave inscriptions on tombstones, as is evidenced by the expression (Horayot 13b); "Others would also include the one who reads the inscriptions on the graves" (vide Shekalim II, 5, 7; Maim. Abel IV, 4).

It is the custom in some localities not to put up a tombstone until twelve months after death, because a tombstone bears marks of distinction and within the twelve months the deceased has anxiety. Another reason for the above custom is that tombstones are put up so that the dead may not be forgotten and as a rule the dead is not forgotten until after twelve months (Berakot 58b). But there are other localities where people are not particular in this regard (Kitzur Shulhan Arukh CXCIX, 17).

It is customary to cover the tombstone with a veil on the day of unveiling, and before the service is begun for one of the mourners to unveil the stone.

PRAYER FOR FORGIVENESS

(Mehilah)

As I stand here on this consecrated spot covering your earthly remains, I pray that I may be forgiven for any unkind word or deed, for any moment of pain or anguish I ever caused you, for any thoughtless or selfish act, for any sin of commission or omission toward you. "For there is no one so righteous upon earth who does good only and sins not." Before God I declare that I bear no ill will for any wrong which you may have wittingly or unwittingly committed against me.

May the recollections of all that was good and noble in your life inspire me to walk ever more firmly in the path of righteousness, to serve ever more nobly my fellowmen.

May God grant you peace. May your soul be bound up in the bond of eternal life, together with the souls of all the righteous. Amen.

AT THE GRAVE OF A SISTER

O heavenly Father, as I stand here at the grave of my dear sister, I fondly recall the happy years we spent together, sharing the love and traditions of our home and family. Her years on earth were too few for those who loved her. Though Thou hast called her back unto Thee, I shall ever hold sacred the memories of her kindness, sincerity, her love and devotion. O Lord, grant that the recollections of her life stimulate me to righteous living. I put my trust in Thee who art the source of all life and my strength in

in time of sorrow. Though a link has been severed from our family chain, help me, O God, to be more closely united with the dear ones who remain. May the soul of my beloved sister be bound up in the bond of eternal life, together with the souls of all the righteous that are in Thy keeping. Amen.

AT THE GRAVE OF A BROTHER

O heavenly Father, as I stand here at the grave of my dear brother whom Thou has called back unto Thee, I fondly recall the years we spent together in happy fellowship. Strengthen me in my sorrow, for his departure has left a void in my heart. May the example of his goodness ever inspire me to consecrate my efforts and talents to every good and noble endeavor. Though a link has been severed from our family chain, help me, O God, to be more closely united with the dear ones who remain. May the soul of my brother be bound up in the bond of eternal life, together with the souls of all the righteous that are in Thy keeping. Amen.

AT THE GRAVE OF A HUSBAND

O heavenly Father, standing here at the grave of the companion of my heart, I fondly recall our sacred bonds formed in Thy presence, the love and friendship he brought into my life, and all the hardships and pleasures, trials and triumphs, joys and sorrows we shared together. The delight of my life, he helped to dispel my fears, and in time

of need, encouraged me and stood at my side. I pray, O Lord, that these precious memories of our happy years together, may ever be an abiding influence for good and an incentive to noble and sanctified living.

Father of all, grant that the soul of my beloved be bound up in the bond of eternal life, together with the souls of all the righteous that are in Thy keeping. Amen.

AT THE GRAVE OF A SON

Almighty Father, standing here at the grave of my beloved child, I tenderly recall the joys that he afforded me during his lifetime. How I delighted in his physical and mental growth! How I planned for his future! Though few and brief were the years wherein I rejoiced with my beloved son, many indeed were the blessings he brought into our home. The passing of years can never fill the void in my heart, nor can time assuage the pain of my bereavement. Though he is no longer in our midst, his memory shall forever be enshrined in my heart.

O merciful God, Giver of life, Thou hast recalled what is Thine own, and has taken him into Thy loving care and keeping. Though my heart still grieves, I have faith that Thou knowest what is best for Thy children. Strengthened by that faith, and cherishing the sacred memory of my child, may I, who have know the joys of parenthood, bring love and cheer into the lives of others. I pray that the soul of my dearly beloved child may be bound up in the bond

of eternal life, together with all the precious souls that are united in Thee, our Creator and Father. Amen.

AT THE GRAVE OF A WIFE

O heavenly Father, standing here at the grave of the companion of my heart, I fondly recall our sacred bonds formed in Thy presence, the love and friendship she brought into my life and all the hardships and pleasures, trials and triumphs, joys and sorrows we shared together. The delight of my life, she helped to dispel my fears, and in time of need, encouraged me and stood at my side. I pray, O Lord, that these precious memories of our happy years together, may ever be an abiding influence for good and an incentive to noble and sanctified living. Father of all, grant that the soul of my beloved be bound up in the bond of eternal life, together with the souls of all the righteous that are in Thy keeping. Amen.

AT THE GRAVE OF A DAUGHTER

Almighty Father, standing here at the grave of my beloved child, I tenderly recall the joys that she afforded me during her lifetime. How I delighted in her physical and mental growth! How I planned for her future! Though few and brief were the years wherein I rejoiced with my beloved daughter, many indeed were the blessings she brought into our home. The passing of years can never fill the void in my heart, nor can time assuage the pain of my bereavement.

Though she is no longer in our midst, her memory shall forever be enshrined in my heart.

O merciful God, Giver of life, Thou hast recalled what is Thine own, and hast taken her into Thy loving care and keeping. Though my heart still grieves, I have faith that Thou knowest what is best for Thy children. Strengthened by that faith, and cherishing the sacred memory of my child, may I, who have known the joys of parenthood, bring love and cheer into the lives of others. I pray that the soul of my dearly beloved child may be bound up in the bond of eternal life, together with all the precious souls that are united in Thee, our Creator and Father. Amen.

BRIDE OR BRIDEGROOM AT THE GRAVE OF A PARENT

Meditation Before Marriage

O heavenly Father, I, who shall soon be united in marriage, stand with mingled emotions at the grave of my father (mother). My joy would be complete if my dear father (mother) could but share this greatest happiness of my life. His (her) fondest hope to rejoice with me when I stand under the canopy of marriage, alas, will not be realized. Thou who knowest best hast, in Thine inscrutable wisdom, summoned him (her) into Thyself.

O God, grant that the blessed memories of my dear departed father (mother) may forever be enshrined in my heart, that his (her) virtues may ever be reflected in the pattern of living I shall set in the home which, by Thy grace,

my beloved and I shall together establish. And throughout married life, may the lofty teachings and noble examples of my father (mother) ever be an inspiration.

In tribute to him (her) may I be true to the vows I shall soon take, and so live that my marriage shall always be pure and holy, free from words that wound and deeds that defile its sanctity and serenity. Grant, O Lord, that our home be a sanctuary wherein Thy spirit shall dwell.

May the soul of my father (mother) be bound up in the bond of eternal life, together with the souls of all the righteous. Amen.

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